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No. 00-

IN THE

Supreme Court of the United States

CHILDREN'S SEASHORE HOUSE,

Petitioner

v.

MICHELLE K. GUHL, Commissioner of the New Jersey Department of Human Services, And MARGARET A. MURRAY, Acting Director of the New Jersey Department of Human Services, Division of Medical Assistance,

Respondents

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Balanced Budget Act of 1997 eliminates the right of hospitals that qualify for supplemental Medicaid payments under §1923 of the Social Security Act ("Disproportionate Share Hospitals") to bring suit under 42 U.S.C. §1983 against state officials who refuse to make these payments.

RULE 14.1(b) STATEMENT

All parties are disclosed in the caption. No party to the case is a public company or an entity described by Rule 29.6.

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Children's Seashore House ("CSH") respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra,* 5a) is reported at 197 F.3d 654 (3d Cir. 1999). The opinion of the district court (App., *infra,* 20a) is unreported.

JURISDICTION

The court of appeals entered its judgment on November 30, 1999. An order denying CSH's petition for rehearing and suggestion for rehearing en banc was entered on February 1, 2000. (App., *infra,* 1a) The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTORY PROVISIONS INVOLVED

42 U.S.C. §1983 provides in pertinent part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable.

The relevant provisions of sections 1902(a) and 1923 of the Social Security Act, codified as amended, respectively, at 42 U.S.C. §1396a(a)(13)(A) and 42 U.S.C. §1396r-4, are reproduced, respectively, at App., *infra,* 33a and 34a-39a.

STATEMENT

This case raises the important question of whether hospitals that treat a "disproportionate share of indigent patients with special needs" may enforce the supplemental statutory reimbursement rights that Congress adopted for their especial benefit under §1923 of the Social Security Act (the "Act" or "Title XIX") in a suit based upon 42 U.S.C. §1983.

A. Statutory Background

Medicaid is a joint state/federal program that provides medical assistance to indigent persons. State participation in Medicaid is voluntary, but states that choose to participate must adhere to various federal requirements, including those which set parameters for payments to hospitals, as a condition of receiving federal financial participation. *See Harris v. McRae,* 448 U.S. 297 (1980). Federal standards governing inpatient reimbursement rates for "institutional" providers (i.e., hospitals and nursing homes) originally were contained exclusively within §1902(a)(13) of the Act. At the outset of the Medicaid program, this provision required retrospective, institution-specific "cost based" reimbursement.

In 1981, Congress amended this standard by enacting the "Boren Amendment." Pub. L. No. 97-35, 95 Stat. 808 (codified at 42 U.S.C. §1396(a)(13)(A)). The Boren Amendment required states to adopt institutional payment rates that are "reasonable and adequate to meet the costs" of "efficiently and economically operated" facilities that provide care and services in conformity with all state and federal standards, and to "assure" the Secretary of Health and Human Services (the "Secretary" of "HHS") that their rates satisfied this standard. *See generally, Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498 (1990) (*"Wilder"*). The Boren Amendment further required that, in adopting their standards and methods for setting Medicaid rates, states "take into account the situation of hospitals which serve a disproportionate share of low income patients with special needs." 42 U.S.C. §1396(a)(13)(A) (1981). Congress included this requirement out of concern that hospitals that treat high levels of indigent patients incur higher costs

than their peers and are more dependent on adequate Medicaid payments for their economic survival.[1]

Out of continuing concern for the economic viability of hospitals that treat a disproportionate number of indigent patients, Congress thereafter ordered the Secretary to report on the progress made in identifying and reimbursing DSH facilities. Consolidated Omnibus Reconciliation Act of 1985 §9519, Pub. L. No. 99-272, 100 Stat. 82. The Secretary's report revealed a "startling record of noncompliance" and a demonstration by many states of "indifference, if not hostility" towards this statutory obligation. H.R. Rep. No. 100-391, 100th Cong., 1st Sess. at 525 (1987). In response, in 1987 Congress added a new §1923 (Pub. L. No. 100-203 §4112, Pub. L. No. 100-360 §411(k)(6), codified at 42 U.S.C. §1396r-4) as a free-standing provision to the Act relating to DSH which severely limited the discretion of the Secretary and the states in this area.

Thus, under §1923(a)(1), 42 U.S.C. §1396r-4(a)(1), Congress specified that states "shall not be considered to meet the requirement" of §1902(a)(13)(A) unless those hospitals that qualify under standards contained in §1923(b) are qualified under their Medicaid State Plans as Medicaid DSH providers and provided with an "appropriate increase in the rate or amount of payment for . . . services provided by such hospitals" which is consistent with "subsection (c) of this section." §1923(a)(1)(B). In §1923(b), Congress mandated that hospitals satisfying either of two formulas relating to their ratio of indigent care will be "deemed" to be Medicaid dispropor-

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1. Congress included this provision because it found that such hospitals generally treat sicker and more costly patients than their peer institutions and are more dependent than their peers on adequate Medicaid reimbursement for their economic survival. *See* H.R. Rep. No. 97-208, 97th Cong., 1st Session at 962 (1981), *reprinted in* 1981 U.S.C.C.A.N. 1010, 1324 ("hospitals which serve a large Medicaid and low income population are particularly dependent upon Medicaid reimbursement"); S. Rep. No. 98-23, 98th Cong., 2nd Sess. (1983), *reprinted in* 1983 U.S.C.C.A.N. at 143, 194 ("Concern has been expressed [that]. . . hospitals [sic] which serve such patients may be more severely ill than average and that the DRG system [authorized by the 1980-81 amendments] may not adequately take into account such factors.")

tionate share hospitals.[2] In §1923(c) Congress set forth three alternative methods from which states must choose in setting appropriate supplemental payments for Medicaid DSH providers.[3]

B. Payments Made to CSH and The Balanced Budget Act Amendments

Petitioner CSH is a specialty hospital that provides acute rehabilitative care to pediatric patients, including infants and children with spinal or brain injuries or severe respiratory disease. Although it still maintains outpatient clinics in New Jersey, CSH relocated its inpatient hospital facility from Atlantic County, New Jersey, to Philadelphia, Pennsylvania in 1990. A substantial proportion of CSH patients are Medicaid recipients and other indigent children. CSH has at all relevant times been certified by its home state of Pennsylvania, in which it participates as a Medicaid provider, as a "deemed" DSH provider under §1923(b). As a result, CSH has regularly received from the Pennsylvania Medicaid agency a significant DSH percentage add-on to its regular per-case Medicaid fees for treating Pennsylvania Medicaid recipients.[4]

Medicaid recipients often receive care in states other than their domiciles, and CSH, by entering into provider agreements with that state, has also consistently participated in the New Jersey Medicaid program.[5] New Jersey, which borders

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2. *See infra,* 17 at fn. 13.

3. *See infra,* 18 at fn. 14.

4. Pennsylvania originally calculated DSH as a percentage adjustment to each "per diem" or "per discharge" fee paid to participating hospitals under Pennsylvania Medicaid's prospective payment system. *See* 55 Pa. Code §1163.67. Beginning in fiscal year 1995-96, Pennsylvania switched to an approach under which it maintained the same DSH judgment formula, but effectively aggregated the case-by-case adjustments and paid DSH adjustments to qualifying facilities on a quarterly basis.

5. This may occur when a patient is out of state and requires "emergency care" or "urgent care," where hospitals in bordering states provide services that are not locally available in the domicile state, or where border state hospitals voluntarily participate and serve patient populations in adjacent states. *See generally* 42 C.F.R. §431.52(b). Under rules promulgated by HCFA to implement 42 U.S.C. §1396a(a)(16), a Medicaid "State Plan must. . . pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if furnished to a recipient who is a resident of the State. . . ." *Id.*

Philadelphia, reimburses out-of-state hospitals that participate in its Medicaid program based upon the Medicaid rates used by those hospitals' home states. N.J.A.C. §10:52-4.4. The New Jersey Department of Human Services ("NJDHS"), which administers that state's Medicaid program, established base per diem Medicaid rates for CSH that were equivalent to Pennsylvania's. NJDHS derived those rates from CSH's Pennsylvania Medicaid rate notice.

Initially, New Jersey's official Medicaid State Plan specified that NJDHS would pay out-of-state hospitals on the basis of the basic Medicaid rates and DSH adjustments established by their home states. On June 30, 1997, NJDHS amended its Medicaid State Plan, specifically to provide that, effective retroactive to September 20, 1996, New Jersey would not pay DSH adjustments to participating hospitals located outside of New Jersey. App., *infra,* 7a. Although it paid CSH based upon its Pennsylvania base Medicaid rates, and although it pays DSH supplements to in-state hospitals that qualify under §1923(b) of the Act, NJDHS declined to recognize CSH's DSH status and refused to supplement the base payment with the percentage add-on that Pennsylvania's Medicaid agency had adopted for CSH under §1923(c) of the Act. Based upon Pennsylvania's DSH percentage formula, the DSH payments withheld from CSH by NJDHS amounted to approximately $2 million during fiscal years 1996 through 1999 (including approximately $780,000.00 in fiscal 1999).

C. The Action and Decisions Below

CSH instituted the action below against officials of NJDHS, acting in their official capacities, in the Federal District Court for the District of New Jersey to enforce its rights to receive the supplemental DSH payments required by §1923. CSH sought declaratory and injunctive relief pursuant to 42 U.S.C. §1983. In support of its claim, CSH alleged that New Jersey had deprived CSH of its right to equal protection of law under the 14th Amendment to the Constitution by paying facially discriminatory rates (i.e., denying DSH supplements) to qualifying out-of-state hospitals. (CSH later sought

leave to amend its complaint to assert an additional claim under the Commerce Clause.) CSH further alleged that, in failing to pay DSH adjustments, NJDHS also was violating sections 1902(a)(13)(A) and 1923 of the Act. In this regard, CSH relied, *inter alia,* on the decision in *West Virginia Univ. Hosps., Inc. v. Casey,* 885 F.2d 11 (3d Cir. 1989), *cert. denied,* 496 U.S. 936 (1990), aff'd *on other grounds,* 499 U.S. 83 (1991), holding that the Act mandates DSH payments to qualifying hospitals and does not recognize state borders as grounds for refusing to pay DSH adjustments. *See id.* at 29 ("[n]othing in §1396a(a) speaks in terms of a dichotomy in rate reimbursement built on state boundary lines").

After this action was filed, and *after* New Jersey amended its Medicaid State Plan to specify that it would not pay DSH supplements to participating hospitals located in other states, Congress amended the Medicaid statute through the Balanced Budget Act of 1997, Pub. L. No. 105-33 (the "BBA"). For State Plan Amendments adopted on or after October 1, 1997, the BBA amended §1902(a)(13)(A), 42 U.S.C. §1396a (a)(13)(A), to eliminate the Boren Amendment's "reasonable and adequate" rate touchstone and Secretarial "assurance" requirements in favor of a requirement that states must establish their base Medicaid rates pursuant to a "public process." 42 U.S.C. §1396a(a)(13)(A)(1997). In the BBA amendments Congress also inserted a new subsection §1902(a) (13)(A)(iv) which mandates that "state plans for medical assistance must" *continue* to include rates which take into account "the situation of" DSH providers "consistent with section 1923."

On September 25, 1998, defendants' predecessors moved to dismiss CSH's action for failure to state a claim upon which relief could be granted. The motion was grounded in the repeal of the former Boren Amendment, which this Court found to support a cause of action against the states under §1983 in *Wilder,* 496 U.S. 498. CSH contended that the BBA amendments had no impact on the pending action since §1923 of the Act, which includes the substantive requirements pertaining to payments to DSH providers, had not been repealed by the BBA amendments to Title XIX, and since §1902(a)(13)(A)(iv) continues to require states to comply with

§1923.[6] CSH further contended that the amendment of §1902(a)(13)(A) had no discernable bearing on the continued viability of its constitutional claim.

By order dated December 7, 1998, the district court dismissed the case, concluding that the Boren Amendment repeal eliminated petitioner's statutory and constitutional claims. *See* App., *infra,* 20a, 32a. On appeal, the Third Circuit reversed in part and affirmed in part. App., *infra,* 3a. The appeals court agreed with CSH that the BBA had no bearing on CSH's right to challenge a state's refusal to pay DSH adjustments to out-of-state hospitals under the Equal Protection clause. App., *infra,* 18a. However, the court of appeals affirmed the lower court's dismissal of CSH's claims predicated on §1923 of the Medicaid Act.

With little analysis or discussion, the court held that the repeal of the former Boren Amendment language eliminated the right of hospitals to sue under the Act and §1983 to redress the withholding of DSH adjustments. In response to petitioner's contention that the right to sue for DSH was centrally predicated on the provisions of §1923 of the Act—rather than on any of the provisions "repealed" by the BBA—the court stated: "We are satisfied that CSH cannot predicate its claim on these provisions." App., *infra,* 15a. The court of appeals acknowledged that various causes of action have been brought under §1983 and provisions of the Medicaid Act *other* than the Boren Amendment, but noted that "none of these cases was predicated upon the current version of" §1923, and that "these cases are all distinguishable from the current situation because each of them rested upon different provisions of the Medicaid Act." App., *infra,* 15a at fn. 3. Petitioner's application for rehearing and rehearing en banc was denied. App., *infra,* 1a.

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6. As noted below (*infra,* 13–14), the BBA actually fortified the rights of DSH providers under §1923 by obligating states to pay DSH adjustments directly to all qualifying hospitals for all services to Medicaid recipients on a "pass through" basis, even in situations where their Medicaid program is operated by managed care companies that are otherwise paid a "capitation fee" by the state to procure services from hospitals and other health care providers.

REASONS FOR GRANTING PETITION

Since 1981 Congress has repeatedly amended the Act to fortify the rights of those hospitals that treat a disproportionate share of indigent patients and effectively serve as the "Safety Net" providers for the Medicaid program. In the face of clear and unambiguous provisions of law designed to ensure specified levels of supplemental payments for such facilities, the Third Circuit has eviscerated their rights to enforce these protections through an action predicated on §1983. In so doing, the court below has created a clearcut conflict among the Circuits on an issue of great importance to a large number of hospitals.

In direct conflict with the Third Circuit, the Ninth Circuit held in *Children's Hosp. and Health Ctr v. Belse,* 188 F.3d 1090 (9th Cir. 1999), *petition for certiorari filed,* 68 U.S.L.W. 3595 (U.S. Mar. 9, 2000) (No. 99-1497), that qualifying hospitals may continue to sue under the Act to challenge the denial of Medicaid DSH adjustments. Furthermore, in direct contrast with the approach taken by the Second Circuit and the decision below, the Ninth Circuit has squarely held in *Exeter Mem'l Hosp. Ass'n v. Belshe*, 145 F.3d 1106 (9th Cir. 1998), that all reimbursement provisions of State Plans adopted prior to the October 1997 BBA effective date — i.e., those adopted when the Boren Amendment language was still included in §1902(a)(13)(A) — remain subject to suit in an action brought under §1983 and §1902(a)(13)(A) of the Act. Accordingly, review by this Court is necessary to resolve a split among the circuits on the broader issue of whether the states remain subject to suit under *Wilder* if their Medicaid programs include ratesetting standards adopted before October 1, 1997.

Review is also warranted in light of the magnitude of the funding implicated by DSH adjustments and the importance of DSH funding to that class of hospitals that treats large uninsured and underinsured populations. DSH payments account for 1 out of every 11 dollars spent under the Medicaid program and the right to receive and assure receipt of these supplemental payments is crucial to those hospitals that bear the heaviest load of caring for indigent patient populations.

Finally, the Third Circuit's determination is also plainly incorrect. The court concluded that suits under §1923 were foreclosed on the basis that Congress had repealed the original Boren Amendment language. However, the lower court simply ignored the fact that Congress had "relocated" the statutory provisions detailing the states' obligations to make DSH payments from §1902(a)(B)(A) of the Act to §1923 of the Act in 1987, and specifically cross-referenced the states' continuing obligations to comply with §1923 in the recently amended version of §1902(a)(13)(A). The decision below also does not survive even a cursory analysis under the established test, illustrated in *Wilder* and in *Blessing v. Freestone,* 520 U.S. 329 (1997), for determining whether a § 1983 action will lie.

I. The Decision Below Creates a Compound Conflict Among the Circuits on Important Medicaid Reimbursement Issues

The decision below creates a two-level conflict among the circuits on important issues arising under Title XIX which should be resolved by this Court.

A. The Decision Below Creates a Conflict Among the Circuits as to Whether Hospitals May Continue to Seek Recourse Against the Denial of DSH Adjustments Under §1923

Even viewed narrowly, this case creates a conflict among the circuits concerning whether hospitals that qualify for Medicaid DSH adjustments were deprived by the BBA of the right to sue under §1983 to enforce their rights under §1923 of the Act. This Court recognized in *Wilder, supra,* that hospitals may sue persons under §1983 who, acting under color of state law, fail to pay or establish institutional Medicaid reimbursement rates in compliance with the standards of §1902(a)(13)(A). Those standards included the rights of participating hospitals to be paid appropriate rates "tak[ing] into account the situations of hospitals which serve a disproportionate number of low income patients." *West Virginia Univ. Hosp., Inc. v. Casey,* 701 F. Supp. 496 (M.D.Pa. 1988), *aff'd,* 885 F.2d 11 (3d Cir. 1989), *cert. denied,* 496 U.S. 936 (1990), *aff'd on other grounds,* 499 U.S. 83 (1991), which was decided

after the enactment of §1923, specifically upheld the rights of Medicaid hospitals to bring a §1983 action against a state that fails to pay DSH adjustments in accordance with federal law.[7]

Children's Hosp. and Health Ctr. v. Belshe, No. C-95-1076 MHP (N.D.C.A. Jan. 16, 1997), *aff'd*, 188 F.3d 1090 (9th Cir. 1999), *petition for certiorari filed*, 68 U.S.L.W. 3595 (Mar. 9, 2000) (No. 99-1497), recently held that the BBA did not affect the rights of hospitals to sue under §1983 to enforce the rights secured by sections 1902(a)(13)(A)(iv) and 1923 of the Act. In direct contrast with the Ninth Circuit's decision, the court below held that the BBA's repeal of the "reasonable and adequate" standard and "assurance" requirements imposed by the Boren Amendment deprived hospitals from "hav[ing] an enforceable statutory claim" under §1923. *See* App. *infra*, 14a-15a. As a result, hospitals located within the Third Circuit are hereafter deprived of the ability to challenge the denial of DSH payments under the very provisions of the Act which mandate those payments. Although hospitals may have still a limited right under the Third Circuit's ruling to contest the *interstate* denial of DSH in actions grounded in the Constitution, the decision below leaves no DSH provider with a meaningful right to protect its entitlement to DSH adjustments under the Act, and it deprives all such hospitals of the ability to seek relief against the unlawful withholding or underpayment of DSH adjustments by their own state. The conflict respecting the right of DSH hospitals to enforce a critically important provision of the Medicaid Act should be resolved by this Court.

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7. Like the case below, *West Virginia Univ. Hosps., Inc.* involved, *inter alia*, the refusal of a state (Pennsylvania) to pay DSH adjustments to a hospital that participated in its Medicaid program but was located in a bordering state (West Virginia University Hospital). As in the instant case, §1983 claims were advanced against the recalcitrant state under both the Equal Protection Clause of the Constitution and the Act. Finding that the Act itself was "border blind" and did not permit rate discrimination against out-of-state hospitals, *West Virginia Univ. Hosp., Inc.* granted relief under Title XIX, and did not find it necessary to reach the merits of the Equal Protection claim. 885 F.2d at 30 & n.9.

B. The Decision Below Widens A Conflict Among the Circuits on the Broader Question of Whether the BBA Amendment Precludes Boren Amendment Based Suits to Challenge Medicaid Rates Adopted Prior to the BBA Amendment

The decision below also widens a conflict among the circuits on the broader issue of whether the 1997 amendment to §1902(a)(13)(A) precludes suits under §1983 and *Wilder* with respect to Medicaid State Plan Amendments adopted prior to the effective date of the BBA. The lower court thus refused to recognize a §1983 action on behalf of CSH in view of the 1997 repeal of the Boren Amendment standards, notwithstanding that the discriminatory State Plan Amendment challenged by CSH was adopted in September 1996 — when the since repealed Boren Amendment standards were in force and effect.

In so ruling, the Third Circuit has aligned itself with the Second Circuit in *Hall v. Sullivan*, 129 F.3d 113 (2d Cir. 1997). There the court vacated a decision awarding institutional providers relief against rates alleged to violate the "reasonable and adequate" standards and dismissed the appeal as moot in view of the BBA amendments and the October 1, 1997 elimination of the "reasonable and adequate" rate requirement and "assurance" standard. *Accord HCMF Corp. v. Gilmore,* 26 F. Supp. 2d 873 (W.D.Va. 1998). In direct contrast, the Ninth Circuit held in *Exeter Mem'l Hosp. v. Belshe*, 145 F.3d 1106, that the BBA amendments had no impact on the rights of institutional providers to sue under §1983 for declaratory and injunctive relief against Medicaid rates or ratesetting standards or methods which failed to satisfy the Boren Amendment requirements under *Wilder* when they were promulgated. *Accord Florida Ass'n of Rehabilitation Facilities, Inc. v. Florida,* 47 F. Supp. 2d 1352 (S.D. Fla. 1999).

Resolution of this broader conflict is critically important to the administration of the Medicaid program. *At least* eighteen (18) states continue to utilize rates and ratesetting methods and standards for institutional providers that were included in Medicaid State Plan Amendments adopted prior to the October 1, 1997 effective date of the BBA amendment

of §1902(a)(13)(A).[8] Under the Ninth Circuit's approach, those states remain subject to suit under §1983 to the extent their Medicaid rates, or the procedures used for arriving at those rates, violate the now-repealed provisions of §1902(a)(13)(A). The opposite result obtains under the approach taken by the Second Circuit and the court below. This Court should grant certiorari to resolve this far reaching issue.

Additionally, the decision below is highly suspect under this Court's decision in *Landgraf v. USI Film Products,* 511 U.S. 244 (1994). *Landgraf* underscores the presumption that legal rights and responsibilities are to be determined under the law in effect at the time the operative acts occurred, not on the basis of after-enacted statutes. "When the intervening statute authorizes or affects the propriety of prospective relief, application of the new provision is not retroactive." *Id.* at 273. The view that pre-BBA State Plans prescribing institutional payment rates are still subject to a §1983 suit predicated on the Boren Amendment standards also finds support in the interpretations of the BBA issued by the Health Care Financing Administration of HHS ("HCFA"). In its implementing instructions, HCFA advised the states that the new public pro-

8. The Secretary does not currently maintain a centralized, comprehensive chronological catalogue of all State Plan Amendments, and a definitive evaluation of how many states maintain pre-BBA ratesetting methods for institutional providers would require the completion of a Freedom of Information Act request directed to each of ten (10) regional HHS offices. Counsel to CSH, however, reviewed the latest edition of the State Medicaid Charts published by the Commerce Clearing House ("CCH") *Medicare & Medicaid Guide*, which informally lists by date the latest State Plan Amendments filed by each state. This survey revealed that the following 18 states or territories had not amended *either* their long term care or their hospital state plan materials (both of which were subject to the Boren Amendment) since the effective date of the BBA: American Samoa; Washington, D.C.; Georgia; Guam; Idaho; Indiana; Iowa; Massachusetts; Montana; Nevada; New Hampshire; N. Mariana Islands; Puerto Rico; Tennessee; Utah; Washington; Wisconsin; Wyoming. The remaining states and territories may have amended either their long term care rates *or* their hospital rates since October 1, 1997 but not both. Accordingly, the number of states still subject to suit, in part, under the Ninth Circuit's approach, may substantially exceed 18.

cess approach governs State Plan Amendments adopted on or after October 1, 1997, but that the "repeal of the Boren Amendment cannot be interpreted to be retroactively effective." Guidance to State Medicaid Directors (Dec. 10, 1997). As the agency charged with administering the statute, HCFA's view — which is consistent with the Ninth Circuit's approach but contrary to that of the Second and Third Circuits — is entitled to deference. *Chevron USA, Inc. v. NRDC*, 467 U.S. 837 (1984); *Martin v. Occupational Safety and Health Review Comm'n*, 499 U.S. 144 (1991).

II. The Availability of Judicial Recourse to DSH Providers Under §1923 Is Socially and Financially Significant

The continuing availability of judicial recourse to DSH providers under §1923 presents a socially and financially significant issue. In requiring supplemental Medicaid payments for those hospitals that treat a disproportionate share of low income patients, Congress determined as a matter of legislative fact that this class of hospitals was vitally important to the delivery of care to Medicaid recipients and charity care patients, and that their provision of "disproportionate" amounts of care to government subsidized or "charity care" patients rendered these same institutions acutely vulnerable to Medicaid reimbursement shortfalls. *See infra.*, at fn. 1. Continued losses by DSH providers may cause such hospitals to limit or reduce services or to shut their doors.[9] In the case at bar, petitioner has alleged that whether or not it receives DSH adjustments determines whether or not it must lose money to extend care and treatment to Medicaid recipients. Accordingly, the very survival of many of these critical access health care providers, and the continued availability of care for large segments of the population, may turn on the hospitals' ability to enforce their rights to DSH payments that comply with §1923.

Moreover, the importance of being able to access DSH payments was heightened by provisions of the BBA. Under

9. As one consequence of Medicaid reimbursement reductions and the increasing penetration of managed care payers, CSH recently reduced its licensed inpatient bed complement.

§4701 of the BBA, Congress relaxed the ability of the states to adopt "mandatory" Medicaid managed care programs without obtaining special statutory "waivers" from HCFA.[10] Under §4721(d) of the BBA, Congress simultaneously enacted a new §1923(i), which obligates all state Medicaid programs to "carve out" the portion of their budgets earmarked for DSH adjustments from their "capitated" payments made to Medicaid managed care organizations, and to directly pay DSH adjustments established in accordance with §1923(c) to those hospitals. Just as Congress has buttressed the rights and protections afforded to DSH facilities, the decision below has removed the teeth from these protective measures of the BBA by declaring that DSH providers may no longer bring suit against state officials who violate §1923.

In addition to being critically important on an institution-specific basis, DSH payments implicate significant portions of state and federal budgets. A recent study[11] observes that DSH payments comprise approximately one out of every eleven dollars expended in the Medicaid program. According to the Government Accounting Office, Medicaid spending amounted to approximately $168 billion annually in fiscal year 1997. GAO Rept. 98-96 (Feb. 1998).

By limiting potential relief for DSH providers to claims against states that discriminate in their DSH payment policy on an interstate basis, the lower court has given a green light to states that—for budgetary or other reasons—may cease to make DSH pass-through payments to hospitals in their own

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10. Prior to the recent enactment of §1932 (BBA §4732(c)), states generally were required under §1902(a)(23)(A) of the Act, 42 U.S.C. §1396a(a)(23)(A), to assure Medicaid recipients the unrestricted choice of obtaining covered healthcare services from any participating provider. States could only divest recipients of this right—and thereby mandate that they receive healthcare services exclusively through a Medicaid managed care organization (such as an HMO) and its selective "network" of providers—by obtaining special "waivers" from the requirements of §1902(a)(23)(A) pursuant to §1115 or §1915(b) of the Act, 42 U.S.C. §§1315, 1396n. Subject to certain exceptions, §1932 authorizes the states to implement mandatory Medicaid managed care programs without such a waiver.

11. T. Coughlin, L. Ku, J. Kim, *Reforming the Medicaid Disproportionate Share Hospital Program in the 1990's* (Jan. 1, 2000) (Urban Institute).

states as required by §1923(i), or otherwise fail to pay DSH supplements that satisfy subsections 1923(b) or (c) of the Act. Plenary review by this Court is necessary to ensure that these important rights can be protected, and so that clear congressional intent to afford special protections to DSH facilities is not turned on is head.

III. The Decision Below Is Plainly Incorrect

Finally, review is warranted because the decision below is manifestly incorrect: there is no valid basis to conclude that §1923 of the Act does not support a claim for relief predicated on §1983. Indeed, petitioner respectfully submits that the conclusion that §1923 does not support a §1983 action is so far off the mark as to warrant summary reversal.

The court below determined that the repeal of the Boren standards formerly included in §1902(a)(13)(A) deprived CSH of the right to sue for DSH adjustments. That conclusion makes little sense in view of the simple fact that the rights CSH seeks to protect are secured by §1923. Not only was §1923 not repealed by the BBA, but §1902(a)(13)(A)(iv) was added by the BBA specifically to reaffirm the states' continuing obligation to abide by §1923, even under the revised rate-setting scheme. Section 1983 entitles an aggrieved entity like CSH to bring suit when persons act under color of state law to deprive it of any right served under federal law. Such rights are not limited to claims based on the Boren Amendment, but may include any provision of Title XIX capable of supporting an action under §1983 under the three-part test applied in *Wilder*.[12] Section 1923 is precisely such a provision.

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12. After having recognized the availability of a cause of action under §1983 for hospitals to enforce their Boren Amendments rights in *Wilder*, this Court applied a somewhat more restrictive test for recognizing a §1983 claim in *Suter v. Artist M*, 503 U.S. 347 (1992). Congress responded in 1994 by legislatively limiting the impact of *Suter* to actions arising under 42 U.S.C. §671(a)(15) through the enactment of Pub. L. No. 103-382, 42 U.S.C. §1320a-2 (1994). That provision relevantly states that a "provision [of the Social Security Act] is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State Plan or specifying the required contents of a State Plan." *See Harris v. James*, 883 F. Supp. 1511,

Without discussion or analysis, the Third Circuit summarily declared that "[w]e are satisfied that CSH cannot predicate its claim on ... [the] provisions of [§1923]" because, in the court's view, this section does not impose either a "substantive or procedural requirement" upon the states. App., *infra*, 15a. That conclusion cannot withstand a plain reading of §1923 or a straightforward application of the established test for ascertaining whether an action will lie under §1983. Under that test, a court must resolve the following three inquiries:

> (1) Did Congress intend the statutory provision in question to benefit the plaintiff?
>
> (2) Is the asserted right not so "vague and amorphous" that its enforcement would strain judicial competence?
>
> (3) Does the statute unambiguously impose a binding obligation on the States? In other words, [is] the provision giving rise to the asserted right couched in mandatory rather than precatory terms.

Blessing v. Freestone, 520 U.S. at 340-41. If these questions are answered affirmatively, a "rebuttable presumption" arises "that the right is enforceable under §1983." *Id.* That presumption can be overcome only in "exceptional cases" where "Congress itself... [makes] it clear that violation of a statute will not give rise to liability under §1983, either by express words or by providing a comprehensive enforcement scheme." *Livadas v. Bradshaw*, 512 U.S. 107 132-33 (1997).

NOTES *(Continued)*

1519 (M.D. Ala. 1995), *rev'd on other grounds*, 127 F.3d 993 (11th Cir. 1997). The lower courts have routinely upheld actions brought by Medicaid providers under §1983 to vindicate rights established for their benefit under a variety of provisions of the Act other than the Boren Amendment. *See e.g., Orthopeadic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998) (suit by hospitals under §1983 to enforce hospital outpatient payment provisions of §1902(a)(30)(A) of the Act, 42 U.S.C. §1396a(a)(30)(A)); *Rite Aid of Pennsylvania, Inc. v. Houston*, 171 F.3d 842 (3d Cir. 1999) (§1983 suit by pharmacies to enforce provisions of the Act relating to payment of reasonable pharmacy fees); *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998) (§1983 suit by recipients to enforce provisions of §1902(a)(8) of the Act, 42 U.S.C. §1396a(a)(8), requiring the "reasonably prompt provision of assistance").

Application of this test firmly establishes the presumption in CSH's favor. First, as the district court recognized (App., *infra*, 27a), there is no serious question that, as a federally qualifying DSH facility under §1923(b), CSH plainly is the intended beneficiary of sections 1902(a)(13)(A)(iv) and 1923. Indeed, the very basis for enacting the DSH provisions was "to assure that payment levels assist these [hospitals] in surviving the financial consequences of competition in the health care marketplace." H.R. Rep. No. 100-391, 100th Cong., 1st Sess. at 524 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-344.

Second, the right of qualifying hospitals to receive DSH payments plainly is not so "vague and amorphous" that its enforcement would "strain judicial competence." *Wilder* held that the courts were fully competent to determine whether a state had adopted a rate that is "reasonable and adequate" to cover the costs of "efficiently and economically operated" hospitals. Even though these standards were not defined either in the Act or regulations, the Court held that concepts of reasonableness and efficiency are a sufficiently "objective benchmark[ ]" for judicial enforcement. 496 U.S. at 519. The DSH standards are far more precisely defined than those found to be enforceable in *Wilder*. Under §1923(b), Congress included two mathematical formulas for identifying certain hospitals which—like CSH—are "deemed" to qualify for Medicaid supplemental DSH payments as a matter of federal law.[13] Under §1923(b) a State Plan is not in conformance with federal law unless the state adopts one of the three congressionally prescribed DSH payment methodologies set forth in §1923(c)(1),(2),(3), 42 U.S.C. §1396r-4(c)(1),(2),(3). Each of

13. These include hospitals with a "low-income utilization rate" (as defined by the Act) which "exceeds 25 percent," and hospitals that have a "Medicaid inpatient utilization rate (as defined in paragraph (2)) [that] is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving payments in the State" in which it is located. §1923(b)(1)(A),(B), 42 U.S.C. §1396r-4(b)(1)(A),(B). States must pay DSH adjustments to hospitals that qualify under either of these standards, but may also utilize more liberal standards under which additional hospitals can qualify for DSH at their election.

these three approaches is decidedly more specific than the "reasonable and adequate" standard.[14] Moreover, judicial enforcement of the DSH standards is further enhanced by interpretive guidance published by HCFA. *See* 55 Fed. Reg. 10077 (Mar. 19, 1990) (describing, *inter alia,* calculation of Medicaid DSH adjustments).

Third, the right to DSH payments under §1902(a)(13)(A)(iv) and §1923 is not merely "precatory." In the BBA Congress inserted a specific reference to paying DSH adjustments in §1902(a)(13)(A)(iv) in accordance with §1923. This is preceded by a mandate in the body of §1902(a)(13) that the states "must" provide DSH adjustments in order for their Medicaid State Plan to qualify for federal funding. At a minimum, those hospitals that, like CSH, satisfy the federal standards in §1923(b) *must* be classified as DSH facilities, and §1923(a) affirmatively obligates the states to pay to such hospitals DSH supplements that comport with §1923(c). As amended by the BBA, §1923(a)(1)(D) specifies that a "State plan under this subchapter shall not be considered to meet the requirements of section 1902(a)(13)(iv) unless" it complies with §1923 (c). 42 U.S.C. §1396r-4(a)(1)(D). Section 1923(a)(1)(B), 42 U.S.C. §1396r-4(a)(1)(B), mandates that states must pay an "appropriate increase in the rate or amount of payment for services provided by such [DSH] hospitals," which is further defined as one that "is consistent with subsection (c) of this

14. Two are mathematical formulas, and one relates to institution-specific costs. Each of the three alternatives allows the exercise of far less discretion by the states than did the Boren Amendment language. The first method requires a calculation of the exact amount of the adjustment to be paid to each DSH facility through use of the base rate multiplied by the hospital's "Medicare" DSH percentage. While the third statutory option under §1923(c)(3)(B), 42 U.S.C. §1396r-4(c)(3)(B) – which is inapplicable here—is less restrictively worded than the first two, HCFA narrowed that option through interpretative guidance that "[w]e do not believe the payment adjustment under the third option would differ significantly from the payment adjustments under the other two options specified in the statute." 55 Fed. Reg. 10077, 10081 (Mar. 19, 1990).

section." *Id.* Thus §1923 mandates actual payments to particular institutions *and* sets specific parameters for setting DSH adjustments.[15]

Nothing in the statute or legislative history rebuts the presumption that a DSH hospital may challenge a state's refusal to pay DSH adjustments under sections 1983 and 1923. To the contrary, Congress specifically enacted §1923 in order to *overcome* a record of "indifference, if not hostility of HCFA, and many of the States" to effecting DSH payments. *See 3, supra.* And, as noted, §1902(a)(13)(A)(iv) was added by the BBA specifically to mandate that each State Medicaid Plan must include rates which "in the case of hospitals, ... take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs."

Indeed, CSH's "presumptive" right to enforce compliance with §1923 under §1983 is further supported by the fact that Congress had proposed in earlier bills to repeal both the Boren Amendment's "reasonable and adequate" requirements *and* to amend the Act itself to expressly bar causes of action related to minimum payment rates. *See, e.g.,* H. R. 2491, 104th Cong., 1st Sess. (1995) §16002 (141 Cong. Rec. S16159-01 at S16247). In the final bill, Congress excluded provisions that would have barred future reimbursement suits by providers

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15. In *Wilder*, the Court inferred a "substantive" obligation for the states to pay "reasonable and adequate" rates from the procedural statutory mandate in §1902(a)(13)(A) that states must "assure" the Secretary that its rates satisfied these standards. 496 U.S. at 509-10. Sections 1902(a)(13)(A)(iv) and 1923 of the Act *directly mandate* the payment of rates that satisfy §1923(c) so that it is unnecessary even to have to "infer" a substantive right to DSH payments from a procedural requirement, as was the case in *Wilder*. Moreover, although States no longer are required under the amended §1902(a)(13)(A) to "assure" HCFA in writing of the "reasonableness and adequacy" of their inpatient hospitals rates, §1923(a)(2)(B), 42 U.S.C. §1396r-4(a)(2)(B), independently requires States to submit State Plan provisions describing their DSH "payment methodology" and reflecting "appropriate increases ... consistent with subsection (c)." *See* HCFA Notice, 63 Fed. Reg. at 54146 (Oct. 8, 1998) ("the Act *requires* the States to provide a description of the methodology it uses ... [which] *must* clarify that ... payments to [DSH] hospitals are made on the basis of the proportion of low-income and Medicaid patients served by such hospitals").

against the states and required the dismissal of pending suits not yet reduced to judgment. "Where Congress includes limiting language in an earlier version of a bill, but deletes it prior to enactment, it may be presumed that the limitation was not intended." *Russello v. United States,* 464 U.S. 16, 21 (1983) (citations omitted). *See Nachman Corp. v. Pension Ben. Guar. Corp.*, 446 U.S. 359, 392-93 (1980). Consistently, the Conference Report on the final bill does not state that all suits under §1902(a)(13)(A) will be eliminated, or, for that matter, even reference a congressional intent to preclude suits under the revised §1902(a)(13)(A) pertaining to the State's compliance with the BBA's public notice process requirements. *See* H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. at 867-68 (1997).[16]

16. The trial court assumed that Congress "has foreclosed the possibility of private enforcement" of the DSH provisions based largely on the statement in H.R. Rep. No. 105-149 (1997) that "it is the Committee's intention that, following the [repeal of the Boren Amendment, the public notice process language] will not be interpreted as establishing a cause of action relative to the adequacy of the rates they receive." *See* App., *infra* 26a. This remark, however, is contained in H.R. Rep. No. 105-149, which accompanied a House Budget Committee version of the Bill that was never enacted as law. Committee pronouncements on unenacted laws are a dubious source of congressional intent. *See Lyons v. Ohio Adult Parole Auth.*, 105 F.3d 1063, 1070 (9th Cir.) *cert. denied* 520 U.S. 1224 (1997); 2A Sutherland Stat. Constr. 48.01 at p. 302. No similar language was included in the Conference Report. Moreover, the quoted language does not even relate to suits to enforce DSH rate standards determined under §1923. Rather, it speaks to the elimination of the suits to enforce the distinct provisions of §1902(a)(13)(A) mandating the payment of "reasonable and adequate" base inpatient hospital and nursing home rates. *Id.* H. R. Conf. Rep. No. 105-217.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 99-5024

CHILDREN'S SEASHORE HOUSE,

Appellant

v.

WILLIAM WALDMAN, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES; KAREN SQUARRELL, ACTING DIRECTOR, OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE

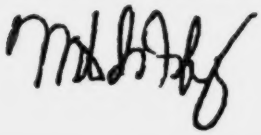
On Appeal from the United States District Court for the District of New Jersey (D.C. Civ. No. 98-02377)

SUR PETITION FOR REHEARING

BEFORE: BECKER, *Chief Judge,* and SLOVITER, MANSMANN, GREENBERG, SCIRICA, NYGAARD, ALITO, ROTH, MCKEE, RENDELL, and BARRY, *Circuit Judges*

The petition for rehearing filed by the appellant, Children's Seashore House, in the above captioned matter having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the court in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court en banc, the petition for rehearing is denied.

BY THE COURT:



Circuit Judge

DATED: FEB. 1, 2000

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 99-5024

CHILDREN'S SEASHORE HOUSE,

Appellant

v.

WILLIAM WALDMAN, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES; KAREN SQUARRELL, ACTING DIRECTOR, OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY

(D.C. No. 98-cv-02377)
District Judge: Honorable Anne E. Thompson

ARGUED BY COUNSEL
September 17, 1999

Present: Greenberg, Scirica and Rendell, *Circuit Judges*

JUDGMENT

This cause came on to be heard on the record from the United States District Court for the District of New Jersey and was argued by counsel September 17, 1999.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court entered December 7, 1998, be, and the same is hereby affirmed to the extent that it dismissed plaintiffs statutory claims; reversed to the [sic] it dismissed the equal protection

claim and reversed and the cause is remanded to the said District Court for further proceedings consistent with the opinion of this Court. The parties will bear their own costs as to this appeal. All of the above in accordance with the opinion of this Court.

P. Douglas Sisk

ATTEST:
Clerk

Dated: November 30, 1999

Filed November 30, 1999

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 99-5024

CHILDREN'S SEASHORE HOUSE,
Appellant

v.

WILLIAM WALDMAN, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES; KAREN SQUARRELL, ACTING DIRECTOR, OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE

On Appeal from the United States District Court
for the District of New Jersey
(D.C. Civ. No. 98-02377)
District Judge: Honorable Anne E. Thompson

Argued September 17, 1999

BEFORE: GREENBERG, SCIRICA, and RENDELL,
Circuit Judges

(Filed: November 30, 1999)

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OPINION OF THE COURT

GREENBERG, *Circuit Judge.*

I. STATEMENT OF THE CASE

Appellant, Children's Seashore House ("CSH"), a Philadelphia hospital that until 1990 had been located in Atlantic City, New Jersey, provides acute medical rehabilitation care to seriously injured or ill pediatric patients. CSH brought this action in the district court on May 8, 1998, seeking declaratory and injunctive relief to compel the New Jersey Department of Human Services to make disproportionate share hospital ("DSH") adjustments on account of CSH's treatment of Medicaid enrollees from New Jersey. In particular, CSH sued the commissioner of the Department and the director of its Division of Medical Assistance ("New Jersey") under 42 U.S.C. § 1983 in their official capacities to challenge New Jersey's amendment to

its Medicaid Plan effective September 20, 1996, which provides for the denial of DSH payments to hospitals located outside of New Jersey. CSH alleged that this policy violated CSH's rights under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* ("Medicaid Act"), and the Equal Protection Clause of the Fourteenth Amendment. New Jersey asserts that it had made the DSH payments to out-of-state hospitals until July 1, 1993, but that thereafter while it was contemplating the amendment's adoption, it discontinued the payments. CSH contends, however, that New Jersey never made DSH payments to it after it moved to Philadelphia.

On September 25, 1998, New Jersey filed a motion to dismiss or in the alternative for summary judgment. On November 9, 1998, CSH filed a motion, which the district court referred to a magistrate judge, to amend its complaint to assert a claim under the Commerce Clause. The district court then decided the case in an opinion dated December 7, 1998, in which it indicated that in its discretion it was determining the "matter as a motion to dismiss" which it granted. Of course, the district court therefore did not make a ruling on the motion for summary judgment, and neither the magistrate judge nor the district court ever ruled on CSH's motion to amend. CSH then appealed.

II. STATUTORY FRAMEWORK

In order that this matter be understood, we set forth the statutory background of the case. Medicaid is a joint federal-state program that provides for the payment of medical services pursuant to the Medicaid Act to the poor, elderly, and disabled. *See Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 845 (3d Cir. 1999). To participate, a state must submit a State Plan to the Secretary of Health and Human Services and obtain its approval of the plan detailing how the state will disburse Medicaid money. *Id.* at 846. A state may change its plan by obtaining approval of a State Plan Amendment. *Id.* The United States makes contributions to a state's program provided its plan is consistent with the applicable Medicaid Act provisions.

Beginning in 1981, Congress provided additional payments for disproportionate share hospitals, meaning

hospitals serving a high percentage of indigent patients. The two provisions regarding DSH adjustments relevant to this case are 42 U.S.C. § 1396a(a)(13)(A) ("a-13") and 42 U.S.C. § 1396r-4 ("r-4"). A-13 provides for a public process through which a state determines and sets reimbursement rates, while r-4 outlines the specifications regarding DSH adjustments. As it now reads a-13 states in its entirety:

> A State plan for medical assistance must —
>
> (13) provide —
>
> (A) *for a public process for determination of rates of payment* under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which —
>
> (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
>
> (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
>
> (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and
>
> (iv) in the case of hospitals, such rates take into account (in a manner consistent with [r-4]) the situation of hospitals which serve a disproportionate number of low-income patients with special needs . . . .

42 U.S.C. § 1396a(a)(13)(A) (emphasis added).

When Congress adopted the current version of a-13 in the Balanced Budget Act of 1997 it repealed the following language, commonly known as the Boren Amendment, that stated:

> A State plan for medical assistance must —
>
> (13) provide —

> (A) *for payment* (except where the State agency is subject to an order under section 1396m of this title) *of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates* . . . which, in the case of hospitals . . . which serve a disproportionate number of low income patients with special needs . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. . . .

42 U.S.C. § 1396a(a)(13)(A) (West 1992) (repealed) (emphasis added).

Both the Boren Amendment and the 1997 amendment to a-13 are cross referenced with r-4. Thus, while r-4 continues to set the parameters for a state's provision of DSH adjustments, Congress in amending a-13 replaced the Boren Amendment's language requiring a state to pay "reasonable and adequate" rates with language mandating that a state provide a "public process" by which rates are determined in accordance with r-4. *See Children's Hosp. and Health Ctr. v. Belshe*, 188 F.3d 1090, 1094 (9th Cir. 1999).

A State Plan must provide for payment for covered services supplied by out-of-state hospitals to the state's own Medicaid program enrollees. *See* 42 U.S.C. § 1396a(a)(16); 42 C.F.R. § 431.52(b); *West Virginia Univ. Hosps. Inc. v. Casey*, 885 F.2d 11, 29 (3d Cir. 1989), *aff'd on other grounds*, 499 U.S. 83, 111 S.Ct. 1138 (1991). Moreover, it is clear that if Congress had not repealed the Boren Amendment in 1997, we would be bound to follow the holdings in *West Virginia v. Casey* that a state cannot set disproportionately low rates for out-of-state hospital services rendered — including DSH adjustments — for its Medicaid enrollees merely because the hospital is an out-of-state provider and that the out-of-state hospitals can enforce their rights to appropriate treatment. *Id.* at 17-22,

28-29; *see also Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 110 S.Ct. 2510 (1990). But inasmuch as we based *West Virginia v. Casey* on our conclusion that Pennsylvania's denial of adjustments to out-of-state hospitals violated the "reasonable and adequate" requirement of a-13 as it then existed, *see* 885 F.2d at 29, we now must determine whether Congress's removal of the "reasonable and adequate" language from a-13 requires a different result than that we reached in *West Virginia v. Casey*. Inasmuch as we conclude that the repeal of the Boren Amendment does require a result different from that in *West Virginia v. Casey* so that CSH cannot prevail on its direct statutory claim, we must decide whether its equal protection claim should have survived New Jersey's motion to dismiss.

III. THE DISTRICT COURT OPINION

As we stated above, the district court dismissed CSH's complaint on New Jersey's motion to dismiss pursuant to Rule 12(b)(6).[1] The court held that CSH lacks standing to bring its statutory claim because Congress intended to foreclose private enforcement of DSH adjustment payments when it repealed the Boren Amendment in 1997, and because r-4 itself did not confer standing on CSH. Applying the test the Supreme Court set forth in *Blessing v. Freestone*, 520 U.S. 329, 117 S.Ct. 1353 (1997), the court recognized that hospitals like CSH are the intended beneficiaries of r-4. The court reasoned, however, that while r-4 mandates that a state's Medicaid plan provide for an appropriate increase in Medicaid payments to DSHs based on specific rate adjustment procedures, unlike the Boren Amendment r-4 "does not mandate actual payment." Accordingly, the court held that r-4 "does not impose a binding obligation on New Jersey to actually afford CSH

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1. New Jersey indicated that it was moving to dismiss pursuant to Fed. R. Civ. P. 12(c). Rule 12(c), however, deals with motions for judgment on the pleadings. As a practical matter, however, in the context of this case there is no real distinction between the two types of motions. *See Churchill v. Star Enter.*, 183 F.3d 184, 190 n.5 (3d Cir. 1999). Thus, inasmuch as the district court treated the motion under Rule 12(b)(6) standards, we will as well.

payment, such that CSH has a federal right to payment under § 1983." Moreover, the court found that Congress's repeal of the Boren Amendment supported this conclusion as Congress eliminated the statutory provision mandating "reasonable and adequate" payment that had been regarded as conferring standing upon plaintiffs in the past. The court found its conclusions buttressed by statements of congressional intent to eliminate causes of action for hospitals and nursing facilities challenging the adequacy of the rates they receive.[2]

When the court addressed CSH's equal protection claim, it held that CSH could not maintain a valid claim because (1) the Medicaid Act does not "specifically" require states to fund out-of-state DSHs; (2) New Jersey was not treating CSH differently than it treated any other out-of-state hospital; and (3) the federal government had approved New Jersey's current Medicaid plan, including its policy not to provide for DSH adjustments to out-of-state hospitals, as conforming with Medicaid's requirements. Nevertheless, the court believed that its ruling was in tension with our rejection of what it called "Pennsylvania's alleged rational basis for excluding out of state hospitals from its Medicaid program" in *West Virginia v. Casey*, 885 F.2d at 29. But the court distinguished that case by pointing out that while "the West Virginia hospital which brought suit served an extremely high number of Pennsylvania residents," "[CSH's] complaint makes no such [equivalent] allegation. . . ." Accordingly, the court dismissed CSH's equal protection claim in addition to its statutory claim to enforce the Medicaid Act.

IV. DISCUSSION

CSH argues that the district court failed to recognize that r-4 authorizes actions to enforce DSH adjustments because r-4 delineates rights established by Congress for the specific benefit of DSHs and obligates the states to make supplemental payments to these hospitals. CSH contends

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2. The court also held that Medicaid's public notice provisions do not confer standing because they "are less than specific, mandatory requirements." CSH does not challenge this conclusion on this appeal.

that, in repealing the Boren Amendment, Congress did not repeal the requirement in r-4 mandating payment of adjustments to DSHs, but actually fortified the states' obligations to these providers. According to CSH, the court's assessment of the legislative history was erroneous, as the court relied upon statements concerning versions of the 1997 amendment to the Medicaid Act that Congress later changed and in any case did not address enforcement of the DSH provisions.

Additionally, CSH asserts that it has alleged a viable 42 U.S.C. § 1983 claim under the Equal Protection and Commerce Clauses. CSH contends that if viewed under either heightened or rational-basis scrutiny, the denial of benefits to hospitals based upon their domiciles violates both clauses. Finally, CSH contends that the district court's reliance on federal approval of New Jersey's plan cannot support its result.

We will affirm the district court's order dismissing CSH's statutory claim seeking to enforce the Medicaid Act with respect to DSH payments in light of the passage of the Balanced Budget Act of 1997 amending a-13. We, however, will reverse the order of dismissal to the extent that it dismissed the equal protection claim and will remand the case to the district court for further consideration of that claim as well as CSH's motion for leave to amend its complaint to assert a Commerce Clause claim.

A. *Standard of Review*

We exercise plenary review over the district court's order granting the motion to dismiss. *See McClintock v. Eichelberger*, 169 F.3d 812, 816 (3d Cir.), *cert. denied*, 120 S.Ct. 182 (1999). Furthermore, we must consider all factual allegations pled in the complaint as true and can affirm the district court's order of dismissal only if we are certain that CSH cannot prove any set of facts in support of its claim that would entitle it to relief. Moreover, regarding CSH's equal protection claim, "[s]ince this is a § 1983 action, [CSH is] entitled to relief if [its] complaint sufficiently alleges deprivation of any right secured by the Constitution. In considering a Rule 12(b)(6) motion, we do not inquire

whether [CSH] will ultimately prevail, only whether [it is] entitled to offer evidence to support [its] claims." *Nami v. Fauver*, 82 F.3d 63, 65 (3d Cir. 1996) (citations omitted).

B. *CHS's Statutory Claim to Enforce the Disproportionate Share Adjustments*

CSH argues that even if Congress's passage of the Balanced Budget Act of 1997 eliminated its ability under a-13 to enforce the DSH adjustments, nevertheless a court can enforce the adjustments under r-4. As noted above, the district court rejected this argument because it reasoned that r-4 does not impose a binding obligation on states to pay the adjustments. A-13 now mandates that a state provide for "a public process" for determination of rates. The process requires publication of the proposed rates together with the methodologies and justifications used to establish to those rates. Providers, beneficiaries, and other concerned state residents must be given a reasonable opportunity for review of and comment on the proposed rates, methodologies and justifications. Then the final rates, as well as methodologies and justifications for the rates, must be published. Finally, the rates must take into account the situation of DSHs in a manner consistent with r-4. *See* 42 U.S.C. § 1396a(a)(13)(A).

In *Blessing v. Freestone*, 520 U.S. at 340-41, 117 S.Ct. at 1359 (citations omitted), the Supreme Court said that a federal statute gives rise to a privately enforceable right if a court finds all three of the following circumstances present:

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States.

We think it is clear that by amending a-13 in 1997, Congress eliminated the Boren Amendment's requirement that a state must provide for and assure the Secretary of Health and Human Services that its rates are "reasonable and adequate." As we recognized in *Rite Aid v. Houstoun*,

the Boren Amendment set procedural and substantive requirements: "The Boren Amendment instructed state agencies to make findings and assurances that their Medicaid reimbursement rates promote economy, efficiency, quality of care, and equal access. . . ." 171 F.3d at 852. Yet, by replacing the Boren Amendment with a requirement that a state establish a public process by which its rates would be determined, Congress has removed a party's ability to enforce any substantive right. *See HCMF Corp. v. Gilmore*, 26 F. Supp.2d 873, 880 (W.D. Va. 1998) ("With the repeal of the Boren Amendment nothing remains that remotely resembles a federal right to reasonable and adequate rates. There is no federal statutory language to parse. There is only a state standard. It follows that there can be no prospective relief under § 1396a(a)(13). . . .").

The legislative history confirms this reading of the statute. H.R. Conf. Rep. No. 105-217 (1997), *reprinted in* 1997 U.S.C.C.A.N. 176, 488, begins its discussion of the proposed change to a-13 with this description of the law under the Boren Amendment:

> Under so-called Boren amendments, states are required to pay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICFs/MR) rates that are 'reasonable and adequate' to cover the costs which must be incurred by 'efficiently and economically operated facilities.' A number of courts found that state systems failed to meet the test of 'reasonableness' and some states have had to increase payments to these providers.

The conference agreement, which became the new a-13, according to the report "[r]epeals the Boren amendments and establishes a public process under which proposed rates, methodologies underlying the rates and the justifications for such rates are published and subject to public review and comment, and final rates are published with underlying methodologies and justifications." *Id.* at 489.

Thus, unless r-4 establishes an enforceable right on its own, CSH does not have an enforceable statutory claim. Yet, r-4 imposes neither procedural nor substantive

requirements on a state that provide a basis for CSH to press its claims. Rather, r-4 is a definitional provision that describes certain procedures that a state must satisfy, such as submitting a qualifying plan to the Secretary of Health and Human Services by a certain date to establish an adequate state disproportionate share hospital adjustment plan. 42 U.S.C. § 1396r-4(a). Moreover, r-4 sets the parameters of what is a DSH, what constitutes an adequate payment adjustment, and what limits are placed on federal financial participation and on state allotments for each year. We are satisfied that CSH cannot predicate its claim on these provisions. For this reason, we will affirm the district court's dismissal of CSH's section 1983 statutory claim and its finding that CSH cannot successfully maintain an action to enforce the Medicaid Act with respect to DSH adjustments.[3]

C. *Equal Protection*

CSH claims that New Jersey's policy discriminates on its face against out-of-state hospitals in favor of domestic enterprises.[4] The Supreme Court has held that according to equal protection jurisprudence, "whatever the extent of a State's authority to exclude foreign corporations from doing business within its boundaries, that authority does not

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3. CSH cites *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 118 S.Ct. 684 (1998), *Rite Aid v. Houstoun*, 171 F.3d 842, and *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998), for the proposition that "[t]he Boren Amendment is only one of several provisions of the Medicaid Act on which providers have based § 1983 claims." Brief at 14. While this is true, none of these cases was predicated upon the current version of a-13 or upon r-4. Moreover, these cases are all distinguishable from the current situation because each of them rested upon different provisions of the Medicaid Act that "unlike r-4" have a substantive or procedural requirement.

4. CSH argues that this denial rises to the level of burdening a fundamental right and is therefore subject to strict scrutiny. However, inasmuch as CSH concentrates its argument upon a rational basis model of equal protection, we will as well. In any event, we have no need at this time to determine whether this is a strict scrutiny case because CSH's complaint survives a motion to dismiss in which only a rational basis justification is implicated.

justify imposition of more onerous taxes or other burdens on foreign corporations than those imposed on domestic corporations, unless the discrimination between foreign and domestic corporations bears a rational relation to a legitimate state purpose." *Metropolitan Life Ins. Co. v. Ward*, 470 U.S. 869, 875, 105 S.Ct. 1676, 1680 (1985) (internal quotation marks omitted).[5]

As we noted above, the district court rested its rejection of CSH's equal protection claim upon its belief that federal law does not require New Jersey to pay out-of-state hospitals because of federal approval of New Jersey's Medicaid plan including New Jersey's express statement that it would not provide for adjustments to out-of-state providers, and because the "current Medicaid statute does not specifically require States to fund DSH facilities outside their own borders." The court distinguished *West Virginia v. Casey* on the ground that "the West Virginia hospital which brought suit served an extremely high number of Pennsylvania residents." Moreover, the court thought that it was significant that New Jersey was not treating CSH differently than other hospitals outside of that state.

New Jersey in a supplemental letter brief urges that we affirm the district court's order dismissing the equal protection claim for the following reasons:

> First, New Jersey does not have sufficient information and data with which to determine whether an out-of-state hospital is entitled to DSH payments under the varying rules for making the determination. Indeed, as set forth in the State's main brief, any state can treat any hospital as a DSH hospital. Second, it would be an onerous task for New Jersey to monitor whether an out-of-state hospital has already been fully compensated by either its home state or other states[6] in

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5. Likewise, the courts consider discriminatory treatment based upon a citizen's state of residence a potential violation of the Privileges and Immunities Clause. *See Lunding v. New York Tax Appeals Tribunal*, 118 S.Ct. 766, 774 (1998) ("Where nonresidents are subject to different treatment, there must be reasonable ground for . . . diversity of treatment.") (internal quotation marks omitted).

6. This assumes that if all states were required to make DSH payments to out-of-state hospitals, other states may also be obligated to make DSH

accordance with 42 U.S.C. § 1396r-4(g), which limits the amount of DSH payments an individual hospital is entitled to receive.

Third, as now codified at 42 U.S.C. § 1396r-4(f), states' DSH allotments were changed so that set amounts are provided for each year beginning with Fiscal Year 1998. Clearly Congress reached a decision about how much each individual state was entitled to receive and there is no evidence that it considered, in its calculation, that a state may be required to give away significant portions of its DSH allotment to other states, particularly given the significant lobbying by the states which occurred prior to the final figures being enacted into law.

Fourth, this calculation is further complicated because it is not possible for New Jersey to anticipate where its residents may ultimately receive care. The statute either applies to out-of-state hospitals or it does not; there is no basis to limit DSH payments only to 'border' hospitals.

Fifth, once a hospital qualifies for a DSH payment, the hospital can use that money for any purpose, even non-medical purposes, because DSH payments are not payments for services provided. Nor would the hospital be required to even use the money received from New Jersey on New Jersey patients.

Lastly, out-of-state hospitals already receive DSH payments from the home state covering care provided to out-of-state residents. The home state is required to take into account treatment of out-of-state indigent patients when determining whether a hospital qualifies for DSH payments and how much DSH that hospital is entitled to receive.

Section 1923(b)(2) of the Act bases the Medicaid utilization rate on a formula that includes patient

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payments to a particular hospital. For example, a hospital could claim a DSH payment from any state as long as it treated at least one resident from that state. [This footnote is quoted from the letter brief.]

> days furnished to patients eligible for Medicaid . . . [t]he State must consider the total number of patient days attributable to Medicaid recipients *regardless of which state would be responsible for payment for the service. This is to ensure that each hospital that meets the . . . [DSH] requirement[s] is accorded disproportionate share status regardless of the origin of those patients. Id.* [55 Fed. Reg. at 10079 (emphasis added)].

It is unreasonable to conclude that Congress intended to have both other states and the home state count the same patient days, and reimburse for the same patient days. These six reasons for New Jersey's denial of out-of-state DSH payments more than satisfies the rational relationship test.

In our view, the district court's rationales cannot support a dismissal of the action. The absence of a provision in the Medicaid Act requiring that states fund DSH facilities outside their borders does not mean that a state constitutionally can differentiate between in-state and out-of-state facilities. Rather, it means simply that there is no statutory requirement for equal treatment. Furthermore, federal approval of the amendment to the plan at most could foreclose a statutory argument challenging the denial of DSH payments. Moreover, the fact that New Jersey treats all out-of-state facilities equally by denying them DSH payments does not address the issue CSH raises as it is complaining about its treatment as compared to treatment of New Jersey facilities, not as compared to treatment of other out-of-state facilities. In the circumstances, we cannot uphold the district court's reasoning on why CSH has failed to allege a claim on which relief can be granted on the equal protection claim.

Additionally, we cannot uphold the Rule 12(b)(6) dismissal on the basis of New Jersey's arguments that we quote above, as its contentions introduce matters into the case that go far beyond the complaint and even the pleadings as a whole and introduce factual questions which we cannot address at this time.[7] In short, we are not

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7. We realize that a court on a motion to dismiss can consider matters of public record, *see Churchill v. Star Enter.*, 183 F.3d 184, 190 n.5 (3d Cir. 1999), but New Jersey's contentions go beyond that record.

satisfied from the complaint or even all the pleadings that CSH will not be able to prove any set of facts that will entitle it to relief.

Accordingly, while we express no view on whether CSH ultimately will prevail on the equal protection claim, we think that the claim should have survived New Jersey's motion to dismiss. *See also West Virginia v. Casey*, 885 F.2d at 29 ("Pennsylvania's excuse of administrative burden does not, in this case, provide a rational basis for [the hospital's] grossly diminished reimbursement rates."). Therefore, we will remand the case to the district court for further proceedings on that claim. On the remand CSH may renew its motion to amend to assert its Commerce Clause claim.

V. CONCLUSION

For the foregoing reasons we will affirm the order of December 7, 1998, to the extent that it dismissed CSH's statutory claims but will reverse it to the extent that it dismissed the equal protection claim. We will remand the matter to the district court for further proceedings consistent with this decision. The parties will bear their own costs on this appeal.

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

NOT FOR PUBLICATION

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

CHILDREN'S SEASHORE HOUSE, *Plaintiff,* v. WILLIAM WALDMAN, Commissioner, of the New Jersey Department of Human Services, and KAREN SQUARRELL, Acting Director of the New Jersey Department of Human Services, Division of Medical Assistance, *Defendants.*	**FILED** **DEC 07 1998** **AT 8:30 _M** WILLIAM T. WALSH CLERK Civil No. 98-2377 (AET) O P I N I O N

THOMPSON, Chief Justice

This matter is before the Court on the motion to dismiss by defendants William Waldman and Karen Squarrell, which was made on their behalf by the Attorney General for the State of New Jersey. The Court decided this motion after hearing oral argument on November 23, 1998. Although the parties have advanced various issues in their briefs, the sole issue in this motion is plaintiff's standing to sue for alleged violations of the Medicaid Act and the United States Constitution under 42 U.S.C. § 1983 ("Section 1983" or "1983"). For the reasons stated herein, defendants' motion will be GRANTED IN ITS ENTIRETY.

BACKGROUND

I. STATUTORY BACKGROUND

Medicaid is a joint federal-state program that pays for medical services provided to indigent persons who would otherwise be unable to afford such care, pursuant to provisions in Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et. seq,* ("Medicaid Act"). To participate, a State must submit a plan to the United States Secretary of Health and Human Services

which details how it will disburse Medicaid assistance, and the Secretary must approve the plan. Such a plan must meet a host of requirements. *See generally,* 42 U.S.C.A. § 1396a, 1396r-4. In short, the federal government matches the contributions of individual States where those States fund indigent healthcare programs consistent with federal Medicaid provisions.

Since 1981, Congress has enacted various provisions specifically addressing hospitals which serve a high percentage, or disproportionate, amount of indigent patients ("Disproportionate Share Hospitals" or "DSH"'s). *See e.g.* 42 U.S.C.A. § 1396a, 1396r-4. The additional subsidies are awarded based upon how many indigent patients a particular facility serves. Two specific portions of the Medicaid provisions relating to DSH facilities are at issue here: 42 U.S.C.A. 1396a(a)(13)(A) ("A-13") and 42 U.S.C.A. 1396r-4 ("R-4"). A-13 sets out a portion of the numerous requirements a State's Medicaid disbursement plan must satisfy before it may gain the federal government's approval. A-13 states:

> [a State's Medicaid plan *must* provide] for a *public process* for determination of rates of payment under the plan for hospital services, . . . under which—
>
> > (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
> >
> > (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
> >
> > (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

> *(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) [known here as R-4] the situation of hospitals which serve a disproportionate number of low-income patients with special needs*

[emphasis added]. Thus, A-13 states that R-4 outlines the specifications for how a State's Medicaid plan must fund DSH facilities. On August 5, 1997, Congress amended A-13. In making the 1997 amendment, Congress repealed, in pertinent part, the following language that was commonly known as the "Boren Amendment":

> [a State's Medicaid plan *must* provide] for *payment* . . . of the hospital services, . . . provided under the plan through the use of rates . . . which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs . . . [and) which the State finds, and makes assurances satisfactory to the Secretary, are *reasonable and adequate* to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws . . . .

[emphasis added]. The Boren Amendment language also included a cross reference to R-4, just as the present statute contains such a cross reference. Therefore, note that in changing the statute, Congress replaced various requirements, including the "reasonable and adequate" standard, with a "public process" requirement. However, further note that Congress left intact the cross reference to R-4 as a basis for determining payment rates for DSH facilities.

Briefly, along with other provisions, R-4 specifically defines DSH facilities by examining how many indigent patients a given hospital serves. *See* 42 U.S.C. 1396r-4(b). This examination does not require a State to determine the residence of indigent patients in calculating whether a given facil-

ity qualifies for DSH assistance. *See id.* Under 1396r-4(a), States' Medicaid disbursement plans must define which hospitals in a given State are DSH facilities using this definition, unless a given State can meet the exception in 1396-4(e), which allows a State to make DSH payments based on more general, aggregate calculations. Congress added the subsection (e) exception in 1998, the same year Congress enacted R-4 itself.

II. FACTUAL BACKGROUND

In May, 1998, plaintiff Children's Seashore House ("CHS") filed its complaint against William Waldman, the former Commissioner of the State of New Jersey's Department of Human Services, and Karen Squarrell, the former Acting Director of the Division of Medical Assistance and Health Services. Michele Guhl is the now the Commissioner and Margaret Murray is now the Director. The New Jersey Department of Human Services administers Medicaid and the New Jersey Division of Medical Assistance operates the program on a day to day basis.

In short, CHS is seeking declaratory and injunctive relief pursuant to Section 1983 based on an alleged wrongful failure to pay DSH subsidies under the Medicaid program. New Jersey's Medicaid program has changed on several occasions, both before and after Congress repealed the Boren Amendment.

It is uncontested that New Jersey stopped making DSH payments to out-of-state hospitals on or about July 1, 1993. *Defendants' Brief,* at 11.[1] However, it was not until June 30, 1997 that the federal government formally approved a Medicaid disbursement plan from New Jersey which specifically stated that New Jersey would not make DSH payments to out-of-state hospitals. *See id.* at 12. The plan containing this

1. Where plaintiff has not contested facts, and where those facts are not in conflict with facts the Court must accept as true, the Court will assume for the purposes of this motion that facts supplied by defendant are accurate.

provision is known as number 96-30B. *Id.* Note that when the federal government approved 96-30B, the Boren Amendment was still in effect, as it was not repealed until approximately one month later.

Although the parties have submitted briefs on various items, the sole issue ripe for review at this time is plaintiff's standing to bring suit under Section 1983. The parties are in disagreement regarding the applicable statutory framework for determining whether plaintiff CHS has standing. Plaintiff asserts that the Boren Amendment is applicable, since New Jersey first adopted 96-30B at a time when Boren was still in effect. In the alternative, plaintiff asserts that it has standing to bring its 1983 claim under either the current Medicaid statute, Medicaid regulations, or Equal Protection doctrines. The Court will address each of these assertions in turn.

In response, defendants assert that the current Medicaid provisions apply and that because the Boren Amendment has been repealed, it is an improper basis upon which to conclude that plaintiff has standing. Defendants further assert that plaintiff's remaining bases for standing are invalid, and that plaintiff's Equal Protection claim should be dismissed as defendants have articulated a legitimate reason for discontinuing DSH payments to out-of-state hospitals.

DISCUSSION

While defendants have filed this motion as a motion to dismiss pursuant to FED. R. CIV. P. 12(c), they have submitted affidavits in support of their motion, When making a determination under FED. R. CIV. P. 12(c), a court cannot consider matters outside the pleadings. When a party presents extraneous materials as part of his or her motion, or opposition thereto, a court has discretion to accept the extraneous material and convert the Rule 12(c) motion to one for summary judgment pursuant to FED. R. CIV. P. 56. *Wiley v. Hughes Capital Corp.*, 746 F. Supp. 1264, 1275 (D.N.J. 1990). In its discretion, the Court will decide the instant matter as a motion to dismiss.

Rule 12(c) provides in relevant part that "[a]fter the pleadings are closed but within such time as not to delay the trial, any party may move for judgment on the pleadings." In this situation, we apply the same legal standards as are used in considering a motion to dismiss under Rule 12(b)(6). *Turbe v. Government of Virgin Islands,* 938 F.2d 427, 428 (3d Cir. 1991).

The court cannot dismiss an action under Rule 12(b)(6) unless it appears beyond doubt that the plaintiff ran prove no set of facts in support of the claims as plead which would entitle the plaintiff to relief. *Conley v. Gibson,* 355 U.S. 41, 45-46 (1957). The factual allegations raised in the complaint must be assumed to be true. *Jenkins v. McKeithen,* 395 U.S. 411, 421 (1969); *Kost v. Kozakiewicz,* 1 F.3d 176, 183 (3d Cir. 1993). The complaint should be construed liberally in the plaintiff's favor, giving that party the benefit of all fair inferences which may be drawn from the allegations. *Wilson v. Rackmill,* 878 F.2d 772, 775 (3d Cir. 1989). "The issue is not whether a plaintiff will ultimately prevail but whether the claimant is entitled to offer evidence to support the claims." *Scheuer v. Rhodes,* 416 U.S. 232, 236 (1974).

PLAINTIFF'S STANDING TO BRING ITS § 1983 CLAIM

I. Boren Amendment (Repealed version of A-13)

Plaintiff first asserts that it has standing to bring its § 1983 claim under the repealed language of the Boren Amendment. Plaintiff further asserts that a standing analysis using Boren is appropriate because the Boren language was in effect when the federal government approved New Jersey Medicaid Plan number 96-30B, which formally discontinued medicaid payments from New Jersey to out-of-state hospitals.

Under Supreme Court precedent which is directly on point, it is clear that plaintiff would have standing if the Boren Amendment were applicable to this case. *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498, 516 (1989); *see also West Virginia Univ. Hosps. v. Casey,* 885 F.2d 11, 21 (3d Cir. 1989), *aff'd on other grounds,* 499 U.S. 83 (1991). However, given the fact that

Congress repealed the Boren Amendment precisely because its language has caused numerous lawsuits, this Court must conclude that Congress has foreclosed the possibility of private enforcement of the Boren Amendment. *See H.R. Rep. No. 105-149* (1997) (stating "it is the Committee's intention that, following the [repeal of the Boren Amendment, the public notice process language replacing that provision] will not be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive."); *H.R. Conf. Rep. No. 104-350* (1995) (stating "the Boren Amendment's vague payment standard resulted in numerous lawsuits . . ."). This Court will not ignore such a clear signal of Congressional intent. Defendants' motion to dismiss will be granted as to plaintiff's claims based on the Boren Amendment.

II. 42 U.S.C. 1396r-4 (Herein R-4)

Plaintiff contends that it has standing to bring its 1983 claims based on R-4. On the other hand, defendants assert that in repealing the Boren Amendment, Congress intended to foreclose hospitals' ability to bring 1983 suits, and moreover, defendants assert that there is no evidence suggesting that Congress intended the R-4 provision to replace the Boren Amendment as a basis for hospitals' 1983 claims. Both parties have cited *Blessing v. Freestone,* 520 U.S. 329 (1997) as the controlling Supreme Court decision for determining whether R-4 gives rise to plaintiff's right to sue under 1983.

Section 1983 allows private parties to bring suit to enforce certain rights conferred by federal statutes. *Maine v. Thiboutot,* 448 U.S. 1 (1980). Before a plaintiff may seek redress though 1983, however, a plaintiff must assert the violation of a federal *right,* not merely a violation of federal *law. Golden State Transit Corp. v. Los Angeles,* 493 U.S. 103, 106 (1989). *Blessing* set forth three factors Courts must use to determine whether a given federal statute gives rise to a federal right.

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the

> plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States.

520 U.S. at 340-41 (citing *Wright v. Roanoke Redevelopment and Housing Authority,* 479 U.S. 418, 430, 431-32 (1987)). If a plaintiff demonstrates that a federal statute creates an individual right, there is a rebuttable presumption that the right is enforceable under § 1983.

An examination of Congressional intent may rebut this presumption. Congress may expressly forbid recourse to § 1983 in the statute itself, or impliedly preclude 1983 suits by creating a broad enforcement scheme that is incompatible with individual § 1983 enforcement. *Id.* at 341. The Court will now analyze R-4 in light of *Blessing,* while focusing on the first and third factors.

Hospitals like CHS are the intended beneficiaries of the R-4 provision. *See Wilder,* 496 U.S. at 513; 42 U.S.C.A. 1396r-4. In conjunction with the current version of A-13, R-4 provides specific rules regarding DSH entitlements for hospitals serving a high proportion of indigent patients. The Court notes that A-13 now mandates that a "public process" provision regarding payments to DSH facilities must be included in a State's Medicaid disbursement plan, as opposed to Boren which required a provision for actual "payment". However, this language did not change the intended beneficiary of the R-4 provision, it merely changed what each State must include in its Medicaid disbursement plan.

The close question in this case is whether R-4 imposes a "binding obligation" on the States that gives rise to an enforceable obligation. In finding that the Boren Amendment imposed a binding obligation, the Supreme Court in *Wilder* focused on the fact that Boren *required* a State to provide some level of actual "payment" to healthcare providers. *See Wilder,* 496 U.S. at 512-13. R-4's language differs from Boren in this respect, since R-4 mandates that a State's Medicaid

plan define what it considers to be a DSH facility, and "provide" for an "appropriate" increase in Medicaid payments to such facilities based on specific rate adjustment procedures. R-4 does not mandate actual payment.

In light of this, and the legislative history given above regarding the repeal of the Boren Amendment, R-4 does not afford CHS standing in this case. R-4 does not impose a binding obligation on New Jersey to actually afford CHS payment, such that CHS has a federal right to payment under § 1983. Therefore, defendants' motion to dismiss will be granted to the extent plaintiffs standing relies on R-4.

III. MEDICAID PUBLIC NOTICE PROVISIONS

Plaintiff has also asserted it has standing to bring suit based upon Medicaid public notice provisions contained in 42 U.S.C.A. § 1396a(a)(13)(A)(i) and 42 C.F.R. § 447.205(c)(3). These provisions leave a great deal of discretion to the States as to how the notice will be published. As such, these provisions are less than specific, mandatory requirements. Instead, they are intended to give guidance to States regarding giving public notice when a State changes its medicaid plan. As such, these provisions are inadequate to create a federal right to sue under § 1983. *Suter v. Artist M.*, 503 U.S. 347, 361-62.[2] Plaintiff's claims based on the Medicaid public notice requirements will be dismissed.

IV. EQUAL PROTECTION

A successful Equal Protection claim "must show that the allegedly offensive categorization invidiously discriminates against the disfavored group." *Kranson v. Valley Crest Nursing Home*, 755 F.2d 46,52 (3d Cir. 1985) (citing *Price v. Cohen* 715 F.2d 87, 91 (3d Cir. 1983), *cert. denied*, 465 U.S. 1032 (1984); See also *Plyer v. Doe*, 457 U.S. 202,, 216 (1982), *reh'g denied*, 458 U.S. 1131. The level of scrutiny used by a reviewing court

2. The Court acknowledges that *Suter's* literal holding has been called into question by Congress. Nevertheless, it remains good law when read in the context of previous Supreme Court decisions.

depends on the classification of the group. In the absence of invidious classification, the government action will be sustained if it bears a rational relationship to a legitimate State interest. *Massachusetts Board of Retirement v. Murgia*, 427 U.S. 307, 312 (1976). Both parties agree that the "rational relationship" standard applies in this case.

Plaintiff has alleged that New Jersey's current Medicaid disbursement plan has wrongfully classified it as not being entitled to Medicare payments in violation of plaintiff's Equal Protection rights. Plaintiff has further alleged that this classification does not bear a rational relationship to a legitimate State interest. Moreover, plaintiff asserts that this Court must accept those allegations as true in considering this motion to dismiss.

The Court first notes that it need not take as true plaintiff's conclusory assertions regarding New Jersey's Medicaid disbursement plan. This Court is not required to accept conclusions which are void of factual or legal support. *See Schuylkill Energy Resources v. PP&L*, 113 F.3d 405, 417 (3d Cir. 1997); *Resolution Trust Corp. v. Farmer*, 823 F. Supp. 302, 305 (E.D. Pa. 1993). Moreover, in the context of this motion to dismiss, the Court may properly examine whether New Jersey's current Medicaid plan meets federal statutory requirements. *United Cerebral Palsy Assocs. of New York State, Inc. v. Cuomo*, 966 F. 2d 743, 744 (2d Cir. 1992) (examining legislative history in context of request for injunction for alleged Equal Protection violation); *Stengel v. Callaham*, 983 F. Supp. 1154, 1165 (N.D. Ill. 1997) (examining legislative history in context of motion to dismiss Equal Protection claim under Social Security Act).

It is undisputed that the federal government has approved New Jersey's current Medicaid plan as conforming with Medicaid's requirements. The current Medicaid statute does not specifically require States to fund DSH facilities outside their own borders. In addition, New Jersey is not treating CSH any differently than it treats other out of state hospitals. The Court is aware that the Third Circuit in *Casey* rejected Pennsylva-

nia's alleged rational basis for excluding out of state hospitals from its Medicaid program. *See* 885 F. 2d at 29. However, that ruling was restricted to the facts of that case, since the West Virginia hospital which brought suit served an extremely high number of Pennsylvania residents. *See id.* at 29. Plaintiffs complaint makes no such allegation and *Casey* is factually distinguishable on that basis. Therefore, the Court will find that New Jersey's current Medicaid disbursement plan does not violate the Equal Protection rights of plaintiff CSH and defendants' motion to dismiss will be granted as to that claim.

ABSTENTION

Defendants have asserted that this Court should abstain from hearing this case on the basis of the *Younger* abstention doctrine. In turn, plaintiff responds that there is no ongoing State judicial proceeding which would necessitate abstention. Since the Court agrees with plaintiff on this issue, the Court will not abstain on *Younger* grounds,

In *Younger v. Harris,* 401 U.S. 37 (1971), the Supreme Court announced an abstention doctrine preventing federal courts from interfering with pending State criminal prosecutions, even where there are allegations of constitutional violations and even though the federal court would otherwise have jurisdiction over the controversy. ERWIN CHEMERINSKY, FEDERAL JURISDICTION § 13.1 at 715-716. The *Younger* doctrine is based on federalism concerns, particularly the rationale of providing proper deference and respect to State judiciaries. *Id.* at 717. Since *Younger,* the Supreme Court has extended this doctrine to require federal courts to abstain from enjoining civil actions where the State is a party, as well as certain actions between private litigants if an important State interest is involved. *See e.g. Trainor v. Hernandez,* 431 U.S. 434 (1977); *Juidice v. Vail,* 430 U.S. 327 (1977). Federal court absention may also be merited under the *Younger* doctrine where there is a pending State administrative proceeding. *Middlesex County Ethics Committee v. Garden State Bar Association,* 457 U.S. 423 (1982).

Both parties agree that there has been some communication between plaintiff and the New Jersey officials responsible for allocating Medicaid assistance. However, nothing presented to this Court evidences a pending State administrative proceeding. Therefore, the Court will not abstain under Younger in this case.

CONCLUSION

For the foregoing reasons, defendants' motion to dismiss will be GRANTED IN ITS ENTIRETY and this case will be CLOSED. An appropriate Order is filed herewith.

Dated: December 7, 1998

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

CHILDREN'S SEASHORE HOUSE, Plaintiff, v. WILLIAM WALDMAN, Commissioner, of the New Jersey Department of Human Services and KAREN SQUARRELL, Acting Director of the New Jersey Department of Human Services, Division of Medical Assistance, Defendants.	:	Civil No. 98-2377 (AET) *ORDER*

THOMPSON, Chief Judge

For the reasons set forth in this Court's Opinion filed even date herewith;

It is on this 7th day of December 1998;

ORDERED that defendants' motion to dismiss shall be **GRANTED IN ITS ENTIRETY** and this case shall be **CLOSED**.

ANNE E. THOMPSON, U.S.D.J.

FILED
DEC 07 1998
AT 8:30 _M
WILLIAM T. WALSH
CLERK

42 USCA s 1396a
42 U.S.C.A. § 1396a

UNITED STATES CODE ANNOTATED
TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 7—SOCIAL SECURITY
SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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Current through P.L. 106-170, approved 12-17-99

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * * *

(13) provide—

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;

42 USCA s 1396r-4
42 U.S.C.A. § 1396r-4

UNITED STATES CODE ANNOTATED
TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 7—SOCIAL SECURITY
SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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Current through P.L. 106-170, approved 12-17-99

§ 1396r-4. Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

(a) Implementation of requirement

(1) A State plan under this subchapter shall not be considered to meet the requirement of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) of this section which meets the requirements of subsection (d) of this section), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c) of this section.

(2)(A) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c) of this section, effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f) of this section, effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this subchapter provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(D) A State plan under this title shall not be considered to meet the requirements of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an

amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1396n(b)(4) of this title.

(b) Hospitals deemed disproportionate share

(1) For purposes of subsection (a)(1) of this section, a hospital which meets the requirements of subsection (d) of this section is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this subchapter in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under

a State plan under this subchapter and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)—

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this subchapter).

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1396b(w)(1)(A)(iii) of this title if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1396b(w)(4) of this title.

(c) Payment adjustment

Subject to subsections (f) and (g) of this section, in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either—

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind

described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1) of this section) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2) of this section) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in subsection (b)(3) of this section); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients,

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a) of this section, the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) of this section (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1395ww(d)(5)(F)(vi) of this title) shall be computed by substituting for the fraction described in sub-

clause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) of this section to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) Requirements to qualify as disproportionate share hospital

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2) (A) Paragraph (1) shall not apply to a hospital—

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of December 22, 1987.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1395ww of this title), in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2) of this section) of not less than 1 percent.

Supreme Court, U.S.
FILED
JUN 0 1 2000
CLERK

(2)

No. 99-1738

In the

Supreme Court of the United States

CHILDREN'S SEASHORE HOUSE,
Petitioner,

v.

MICHELE K. GUHL, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF THE RESPONDENTS IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Did the Court of Appeals for the Third Circuit and the district court correctly determine that petitioner had no standing to bring the 42 U.S.C. § 1983 complaint alleging violation of the provisions of Title XIX of the Social Security Act in regard to disproportionate share payments to out-of-state hospitals.

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STATUTORY PROVISIONS INVOLVED

Petitioner only set forth part of section 1923 of the Social Security Act, codified at 42 U.S.C. § 1396r-4, in its appendix. As the respondents refer to other portions of that statute in this brief, the entire section is reproduced at App., *infra*, 1a.

STATEMENT OF THE CASE

This interlocutory petition for a Writ of Certiorari seeks to appeal part of the decision of the Court of Appeals for the Third Circuit, finding that petitioner has no standing under 42 U.S.C. § 1983 to bring this action based upon the current hospital reimbursement provisions of Medicaid law.

A. The Action and Decision Below

The complaint in this matter was filed in the federal district court for the District of New Jersey on May 8, 1998, after the Boren Amendment was repealed by Congress and replaced by the Balanced Budget Act of 1997. It alleged claims pursuant to 42 U.S.C. § 1983 for alleged violations of Medicaid law and the Equal Protection Clause against officials of the State of New Jersey acting in their official capacity only. Consequently, the only relief sought and available is prospective injunctive relief, as any other relief would be barred by the Eleventh Amendment. *Will v. Michigan Dept. of State Police*, 491 U.S. 58 (1989).

On December 8, 1998, the district court granted the State's motion to dismiss for failure to state a cause of action. The district court held that Children's Seashore House had no standing to bring its claim based upon Medicaid Law and that its Equal Protection Clause claim was without merit.[1]

Children's Seashore House appealed to the United States Court of Appeals for the Third Circuit. On November

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[1] Children's Seashore House sought to amend its complaint to add a claim pursuant to the Commerce Clause which was never addressed by the district court.

30, 1999, the Third Circuit affirmed in part, reversed in part and remanded the matter back to the district court. The Third Circuit agreed with the district court that Children's Seashore House did not have standing to pursue its claim premised on the Medicaid Act, but found further fact finding was needed on the Equal Protection claim. In addition, the Third Circuit stated that on remand Children's Seashore House could renew its motion to assert its Commerce Clause claim. This matter is currently pending before the district court on Petitioner's claims pursuant to the Equal Protection Clause and the Commerce Clause.

B. Statutory Background

The Medicaid program is a joint federal-state program designed to provide medical assistance to individuals "whose income and resources are insufficient to meet the cost of necessary medical services." 42 U.S.C. § 1396. Although a state is not required to participate in the program, once a state has been accepted into the program, it must comply with the Medicaid statute and federal regulations. *Harris v. McRae*, 448 U.S. 297 (1980). As required by 42 U.S.C. § 1396a(a)(5), the Department of Human Services (DHS) has been designated as the single state agency responsible for administering the Medicaid Program in New Jersey; the Division of Medical Assistance and Health Services (DMAHS) is charged with responsibility for the daily operation of the program. N.J.S.A. 30:4D-3(c), 30:4D-5.

The State of New Jersey, in conformity with 42 U.S.C. § 1396a(a), must submit a State Plan to the United States Department of Health and Human Services (HHS) for approval. The State Plan describes the policy and methods used to set payment rates for each type of service included in the program in order to qualify for federal matching funds and to ensure that its program conforms to federal requirements. The State Plan, and any subsequent proposed amendment (State Plan Amendment or SPA) must meet federal requirements. 42 U.S.C. § 1396a(b); 42 C.F.R. §§ 430.10,

430.12. *See Rite Aid of Pennsylvania v. Houstoun*, 171 F.3d 842, 846 (3rd Cir. 1999). All initial State plans and amendments are approved or disapproved by the Health Care Financing Administration (HCFA), acting for the Secretary of HHS.

Prior to legislation enacted by Congress in 1980 and 1981, certain institutional providers, including hospitals, were reimbursed by state Medicaid agencies on a reasonable cost basis, 48 Fed. Reg. 56046 (1983). The 1981 legislation changed the standard for reimbursement of nursing and intermediate care facilities. Pub.L. No. 96-499, § 962(a) required that the rates paid to these providers through states' Medicaid programs be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." In 1981, the controlling statute, 42 U.S.C. § 1396a(a)(13)(A), was again amended to include hospitals, and to require, *inter alia*, that states "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs." Pub.L. No. 97-35, § 2173. This change is known as the "Boren Amendment." As amended, Section 1396a(a)(13)(A) provided in relevant part as follows:

> A State plan for medical assistance must-- ... provide-- ... for payment ... of the hospital ... services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs ...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the

> costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital ... and periodic audits by the State of such reports....42 U.S.C.A. § 1396a (West Supp.1989). [*West Virginia University Hospitals v. Casey*, 885 F.2d 11, 22 (3d Cir. 1989)].

Although the Secretary of Health and Human Services promulgated regulations designed to implement the Boren Amendment, the regulations did not include explicit criteria for federal review of states' methods and standards for establishing payment rates. Such a list, the Secretary concluded, might be viewed as imposing federal standards for payments rates, and as such would have been contrary to Congress' intent, which placed the responsibility for developing such rates upon the states, 48 Fed. Reg. 56049 (1983). The regulations only required that a State, in order to receive HCFA approval of a State plan change in payment methods and standards, must:

> (a)...make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (i) of this

section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) Findings. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) Payment rates.

(i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to inpatient hospital services--

(A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with

special needs...[42 C.F.R. § 447.253].[2]

A subsequent statute, 42 U.S.C. § 1396r-4, implementing the requirements of 42 U.S.C. § 1396a(a)(13)(A), was added by Congress on December 22, 1987. It required states to submit a SPA to the Secretary by July 1, 1988, defining disproportionate share hospitals, and providing for increased payments to those hospitals as of July 1, 1988. Pub. L. No. 100-203, Title IV, § 4112. [3]

On September 30, 1988, New Jersey submitted to HCFA SPA 88-29, which was intended to comport with 42 U.S.C. § 1396r-4. This SPA covered disproportionate share ("DSH") payments to various types of hospitals. It indicated that New Jersey had a statewide pooling arrangement in accordance with 42 U.S.C. § 1396r-4(e), and stated that New Jersey would "reimburse disproportionate share hospitals located in a state other than New Jersey according to the approved Title XIX (Medicaid) reimbursement methodology in the state in which the hospital is located." SPA 88-29 was

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[2] HCFA has proposed to amend the regulations to remove this entire provision as it is inconsistent with the Balanced Budget Act of 1997, discussed *infra*. 64 Fed.Reg. 54263 (1999).

[3] Also in 1988, several amendments were made to 42 U.S.C. § 1396r-4, adding language which created an exception to the original requirements imposed by that statute. New Jersey and other states that met certain criteria came under § 1396r-4(e), captioned "special rule," which permitted states to limit DSH payments to acute care hospitals involved in a statewide "pooling arrangement." The statewide pooling arrangement referred to in the "special rule" was a function of New Jersey's unique hospital rate-setting system. At the time 42 U.S.C. § 1396r-4(e) was enacted, New Jersey hospital rates were set by statute, under an "all-payor" system which set the rates charged by hospitals for the various paying entities. L.1978 c. 83 (Chapter 83). This rate system included a statewide pooling arrangement, whereby all hospitals collected an assessment to reimburse those hospitals which paid for a "disproportionate share" of "uncompensated care."

later split into four parts; the out-of-state portion was designated as SPA 88-29(d).[4]

In 1992, New Jersey's hospital rate setting system was invalidated by the decision in *United Wire, Metal & Machine Health and Welfare Fund, et al. v. Morristown Memorial Hosp.*, 793 F.Supp. 524, (D.N.J. 1992), and the system was replaced by the State Legislature.[5]

Under the Health Care Reform Act of 1992, L. 1992, c. 160, (Chapter 160), N.J.S.A. 26:2H-18.51 *et seq.*, effective January 1, 1993, the State replaced the rate-setting system with a deregulated, free market system by calendar year 1994 (1993 served as a transition year). In enacting Chapter 160, the Legislature recognized a "need to continue this State's current system of providing disproportionate share payments to hospitals in the State," and thus created a funding source for the State's hospitals. N.J.S.A. 26:2H-18.51(c). Under Chapter 160, disproportionate share hospitals are designated as such by the Commissioner of Human Services. N.J.S.A. 26:2H-18.52. The actual payment of the charity care subsidy, because it constitutes a DSH payment, is done through DMAHS, so that the State can then submit claims for federal financial participation (FFP). While the exact formulas for distributing charity care have changed on several occasions since 1992, as the result of legislative amendments, the basic concept has remained unchanged.

Charity care payments, including DSH payments, are made from the Health Care Subsidy Fund created by Chapter 160. The Fund is a "nonlapsing fund" dedicated for

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[4] As explained *infra* at n.8, this SPA was superseded the same day it was approved.

[5] The issue in *United Wire* was unrelated to any issues in this matter. The decision in *United Wire* was overturned in *United Wire, etc. v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3rd Cir. 1993), *cert. denied sub nom, New Jersey Carpenters Welfare Fund v. Dunston*, 510 U.S. 944 (1993), but the State Legislature had already changed the payment system.

use by the State to (among other things) distribute charity care subsidy payments to hospitals. N.J.S.A. 26:2H-18.58(a). Funding for these charity care payments currently comes from several sources as determined by the Legislature. N.J.S.A. 26:2H-18.58(a), N.J.S.A. 26:2H-18.58c. In each year since 1993, the Legislature has provided a specific, set amount to be distributed. This fund is distributed to in-state hospitals pursuant to specific statutory formulas (which have varied from year to year). The formulas do two things: first, they identify which particular acute care hospitals will be eligible in a given year, and second, they determine how the limited subsidy amount for that year will be distributed among those eligible hospitals. *See* N.J.S.A. 26:2H-18.59, and 59e. Not every acute care hospital in the State is eligible for or receives a charity care subsidy in a given year. Nor does the subsidy act as a strict "reimbursement," covering all of a hospital's charity care expenses. Rather, it represents a particular hospital's percentage of the limited State-wide subsidy amount, as set by the Legislature for that year.

Certain hospitals also receive an additional DSH payment adjustment from the Hospital Relief Subsidy Fund. N.J.A.C. 10:52-8.2(a)(4). This additional payment is based upon the facility's percentage of clients with AIDS, tuberculosis, substance abuse and addiction and complex birth.

During the time that New Jersey was revising its hospital rate setting methodology, and after it had been informed by HCFA that it did not need to make DSH payments to out-of-state hospitals,[6] the State stopped making

[6] DMAHS Director Saul M. Kilstein was informed by William L. Engelhardt, Acting Associate Regional Administrator of HCFA, in a letter dated June 21, 1993, that the State could, if it wished, withdraw SPA 88-29(d) (which had not yet been approved by HCFA), because it was not required to make DSH payments to hospitals outside of the State's DSH pool, pursuant to 42 U.S.C. § 1396r-4(e).

DSH payments to out-of-state hospitals, on or about July 1, 1993.[7]

An amended SPA concerning, *inter alia*, DSH payments to out-of-state hospitals, SPA 96-30, was submitted to HCFA on or about September 30, 1996. This SPA was subsequently divided into two separate SPAs, and the part that concerned DSH payments to out-of-state hospitals was redesignated as SPA 96-30B. That SPA states that "[t]he New Jersey Medicaid Program will not make disproportionate share hospital payments to any facility located in a state other than New Jersey." It was approved by HCFA on June 30, 1997, and had an effective date of September 20, 1996.[8]

The most significant event for purposes of this matter occurred on August 5, 1997 when President Clinton signed the Balanced Budget Act of 1997 (BBA). Section 4711 of the BBA replaced the Boren requirements with a new Section 1902(a)(13)(A) of the Social Security Act. The new statute requires the State plan to provide

> (A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services

[7] On page 5 of its petition, Children's Seashore House asserts the amount it believes it would have been entitled to in DSH payments from New Jersey during fiscal years 1996-1999. These figures were neither presented to the district court nor the Court of Appeals below and the respondent contests the accuracy of those amounts. Moreover, the complaint in this matter only seeks prospective relief, as the Eleventh Amendment would bar any claim for retroactive monetary damages, and the complaint was not filed until May 8, 1998, after the statutory changes repealing the Boren Amendment.

[8] On that same date, June 30, 1997, HCFA also approved SPA 88-29(d), with an effective date July 1, 1988. However, SPA 88-29(d) was immediately superseded by SPA 96-30B.

> of intermediate care facilities for the mentally retarded under which --
>
> (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
>
> (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
>
> (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and
>
> (iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs... [42 U.S.C. § 1936a(a)(13)(A)].[9]

Thus, the State no longer must make "findings" and "assurances" to the Secretary that the reimbursement rates are "reasonable and adequate" to meet the costs which must be incurred by "efficiently and economically operated facilities"

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[9] The BBA was signed into law on August 5, 1997, and these provisions apply to services furnished on or after October 1, 1997. Pub. L. No. 105-33, § 4711(d).

in order to provide care and services in conformity with applicable laws, regulations and quality and safety standards or to assure that individuals eligible for medical assistance have "reasonable access" to inpatient hospital services of adequate quality. Also removed is the requirement for periodic audits.

The BBA also set state-specific DSH allotments. Now codified at 42 U.S.C. § 1396r-4(f), states' DSH allotments were changed so that set amounts are provided each year beginning with Fiscal Year 1998. Congress reached a decision about how much each individual state was entitled to receive and there is no evidence that it included in its calculations that any state be required to give away significant portions of its DSH allotment to other states.

After the enactment of the BBA and in accord with the public process requirements of the BBA, the State adopted a regulation, N.J.A.C. 10:52-4.4(b), which provides that "[t]he Division shall not reimburse out-of-State hospitals for disproportionate share hospital (DSH) payments even if the DSH payments are included in the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located." N.J.A.C. 10:52-4.4(b) was proposed on April 6, 1998, 30 N.J.R. 1258(a), and adopted on June 18, 1998, effective July 20, 1998, 30 N.J.R. 2653(a), following the public comment period.[10]

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[10] The State did not actually have to comply with the public notice requirements. HCFA has interpreted the statutory language of the BBA to mean that States are not required to subject their existing rates to a public process. *See*, December 10, 1997 letter to State Medicaid Directors, from Sally K. Richardson, 18a. This interpretation is entitled to deference. *See, e.g., Planned Parenthood Affiliates of Michigan v. Engles*, 73 F.3d 634 (6th Cir. 1996), discussing a similar letter from Sally K. Richardson which was also sent to all state Medicaid Directors, and noting that the court would "accord deference to this reasonable agency interpretation of the statutory requirements of Medicaid" (*Id.* at 638, citations omitted).

REASONS FOR DENYING WRIT

In this case, petitioner Children's Seashore House ("CSH") is not challenging the rates it receives for treating Medicaid recipients from New Jersey as inadequate. Rather, petitioner is challenging New Jersey's refusal to give it an extra payment, known as a DSH payment.[11] The DSH payment is not payment for services rendered and is not related to medical care. Rather, it is a subsidy to compensate a qualifying hospital for the high percentage of otherwise uncompensated care provided by the hospital. Petitioner already receives a DSH payment from its home state, Pennsylvania, which must take into account all charity care provided by CSH, including those charity care patients it treats from other states. 55 Fed.Reg. at 10079 (1990), 21a.

The courts below correctly held that CSH did not have standing to pursue this 42 U.S.C. § 1983 action predicated upon an alleged violation of Medicaid law. Following the repeal of the Boren Amendment, the new statutory scheme does not impose a binding obligation on New Jersey to make any "payments" to hospitals. The only requirement is that the State have "a public process" for determination of rates of payment. Consequently, as the three-prong test enunciated by this court in *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 106 (1989) and *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997), to determine whether a plaintiff has standing to bring this action has not been met, the courts below properly dismissed the claim, and there is no basis for granting certiorari.

In addition, petitioner posits a split in authority based upon this case and the Ninth Circuit's split decision in

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[11] Petitioner's allegation in footnote 9 on page 13 of its petition that it recently reduced its licensed inpatient beds due to Medicaid reimbursement reductions was never presented to the district court nor the Court of Appeals below and the respondent does not admit that this is an established fact. Moreover, this matter only concerns DSH payments, not payment rates in general.

Children's Hosp. and Health Ctr v. Belshe, 188 F.3d 1090 (9th Cir. 1999), *petition for certiorari filed*, 68 U.S.L.W. 3595 (U.S. Mar. 9, 2000)(No. 99-1497). However, the matter in the Ninth Circuit was originally filed in 1995, before the enactment of the BBA. In contrast, the case at bar was filed in May 1998, after the enactment of the BBA, and the petitioner waived its argument that the Boren Amendment still applied on appeal to the circuit court. Moreover, the Ninth Circuit never addressed the standing issue present in this matter. In addition, contrary to California, New Jersey followed the public process required by the BBA. Therefore, under either the Ninth Circuit's analysis or the Third Circuit's analysis, the result would be the same and there is no irreconcilable split meriting the attention of this Court. Finally, the circuit court did not apply the BBA retroactively as this matter was filed after the BBA was in effect. Consequently, a circuit court decision as to whether hospitals can continue to sue under the repealed-Boren Amendment is irrelevant to the case at bar.

Furthermore, petitioner's argument regarding the "social and financial" need for a private cause of action to enforce the DSH provisions is not an adequate reason to grant certiorari. Hospitals do not have standing to sue pursuant to § 1983 in accordance with the well-established test for making such determination. Consequently, there is no basis for granting certiorari based upon public policy considerations best left to the legislative action.

Lastly, this is an appeal of an interlocutory order. The matter is currently proceeding in the district court following the remand by the Third Circuit. There is no pressing need for this Court to hear this matter on an interlocutory basis.

I. The Decision Below Correctly Determined That CSH Had No Standing to Bring this Lawsuit

The courts below correctly held that CSH does not have standing to bring this lawsuit pursuant to 42 U.S.C. § 1983. Consequently, this petition is without merit.

"Section 1983 provides a cause of action for 'the deprivation of any rights, privileges, or immunities secured by the Constitution and laws' of the United States." *Wilder v. Virginia Hospital Assoc.*, 496 U.S. 498, 508 (1990). Section 1983 provides a cause of action for violations of federal statutes as well as the Constitution. *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980). However, a plaintiff will not be permitted to sue under § 1983 where the statute does not create enforceable rights, privileges or immunities within the meaning of § 1983 or where Congress has foreclosed such enforcement in the statute in the enactment itself. *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 423 (1987).

In order to determine whether a federal law creates a "federal right" that is enforceable under § 1983, courts apply a three-prong test. First, the court must determine whether "the provision in question was intend[ed] to benefit the putative plaintiff." *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 106 (1989) (citations and internal quotations omitted). Second, if the provision was intended to benefit the putative plaintiff, the court must determine whether the provision merely reflects a "congressional preference" for a certain kind of conduct rather than a binding obligation on the governmental unit. Only a binding obligation is enforceable. *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 19 (1981). Third, there is no enforceable right where the interest the plaintiff asserts is "'too vague and amorphous'" such that it is "'beyond the competence of the judiciary to enforce.'" *Golden State, supra*, 493 U.S. at 106, quoting *Wright, supra*, 479 U.S. at 431-32. *See also Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997).

A. Hospitals Are Not the Intended Beneficiary

Applying the three-prong test in this case, it is clear that health care providers are no longer the intended beneficiaries of the reimbursement system. Contrary to the prior language of the Boren Amendment which required the state plan to provide for "payment," *Wilder*, 496 U.S. at 510, the new legislative scheme only requires the state plan to provide for "a public process" for determinations of rates of payment. 42 U.S.C. § 1396a(a)(13)(A). Thus, the first prong of the three prong test -- that health care providers are the intended beneficiaries -- is not met.[12]

B. The BBA Does Not Impose a Binding Obligation on the States to Make DSH Payments to Hospitals

Even assuming *arguendo* that the first prong could be met, the second prong -- whether the legislative scheme imposes a binding obligation on the States -- cannot be met. First, the only binding obligation imposed by the new scheme is to have a "public process" in place. 42 U.S.C. § 1396a(a)(13)(A). While that process includes publication of proposed and final rates, along with the underlying methodologies for establishing those rates and the justifications for those rates, there is no requirement as there was with the Boren Amendment that the states make findings and assurances that the rates are "reasonable and adequate." As stated by the Third Circuit

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[12] Even if health care providers are still intended beneficiaries, the State does not concede that out-of-state providers, as opposed to in-state providers, are the intended beneficiaries. Indeed, as set forth below, HCFA has taken the position that the hospital reimbursement provisions do not apply to out-of-state providers.

> [B]y replacing the Boren Amendment with a requirment that a State establish a public process by which its rates would be determined, Congress has removed a party's ability to enforce any substantive right. [*Children's Seashore House v. Waldman*, 197 F.3d 654, 659 (3d Cir. 1999) (citations omitted)].

Nor does 42 U.S.C. § 1396r-4 create a binding obligation on the States. Again, as the Third Circuit noted,

> [42 U.S.C. §1396]r-4 imposes neither procedural nor substantive requirements on a state that provide a basis for CSH to press its claims. Rather, r-4 is a definitional provision that describes certain procedures that a state must satisfy, such as submitting a qualifying plan to the Secretary of Health and Human Services by a certain date to establish an adequate state disproportionate share hospital adjustment plan. 42 U.S.C. § 1396r-4(a). Moreover, r-4 sets the parameters of what is a DSH, what constitutes an adequate payment adjustment, and what limits are placed on federal financial participation and on state allotments for each year. We are satisfied that CSH cannot predicate its claim on these provisions. [*Children's Seashore House*, 197 F.3d at 659-60].

The legislative history of the BBA makes clear that in repealing the Boren Amendment, Congress intended to foreclose further lawsuits against the states. CSH's assertions to the contrary notwithstanding, the amendment was designed to free states from excessive federal oversight, and to eliminate the use of the Boren Amendment by hospitals and nursing facilities as a basis for seeking judicial review as to the adequacy of the rates established by the states. The House Report explicitly declared, "It is the Committee intention that, following enactment of this Act, neither this nor any other provision of Section 1902 will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive." H.R. Rep. No. 110-149, at 591. That report also noted that under the Boren Amendment, "[a] number of courts found that state systems failed to meet the test of reasonableness and some states have had to increase payments to these providers as a result of these judicial interpretations." H.R. Rep. No. 149, *supra*, at 591, *accord*, H.R. Conf. Rep. No. 217., 105th Cong., 1st Sess. 867 (1997). "The Boren amendment has produced endless lawsuits ... Repealing the Boren amendment takes it out of the courts." Cong. Rec. S6305 (June 25, 1997), statement of Sen. Gramm.

House Conference Report No. 105-217 of July 30, 1997, the House/Senate conference agreement dealing with the Boren Amendment, taken as a whole, demonstrates a clear intent to repeal the Boren Amendment, and does not support the interpretation given by petitioner. The statement of the current law in the House Report (prior to the adoption of the BBA) acknowledges that courts were invalidating states' plans, and both the House and Senate reports state the intent to repeal the Boren Amendment. *See generally United States v. Congress of Industrial Organizations*, 335 U.S. 106, 112-13 (1948)(remedial laws are to be interpreted in light of previous experience and prior enactments).

Contrary to petitioner's argument that the BBA strengthened the DSH provisions, the final version of the BBA did not adopt the language of the House version which

specifically required that states take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs, and make assurances that the average level of payments made to hospitals would not drop for an 18 month period. A fair reading of the legislative history supports the State's position that the BBA was intended to limit suits brought under the Boren Amendment. *HCMF Corp. v. Gilmore*, 26 F.Supp.2d 873, 879 (W.D. Virginia 1998) ("The Balanced Budget Act of 1997 replaced the repealed Boren Amendments standard with a public notice process for states to follow in setting payment rates. There can be but one reasonable conclusion from Congress's action: Congress precluded a right of action under § 1983 for reimbursement claims for services rendered on or after October 1.")

Even if there is a binding obligation to make DSH payments to in-state hospitals, the language of § 1396r-4 simply does not indicate any requirement to make DSH payments to out-of-state providers. It is well settled that "[i]n statutory interpretation, the starting point is always 'the language [of the statute] itself.'" *Queen of Angels/Hollywood Presbyterian Medical Ctr. v. Shalala*, 65 F.3d 1472, 1477 (9th Cir. 1995)(citations omitted). Under step one of the now familiar two-part test enunciated in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984), a reviewing court first determines "whether Congress has spoken directly to the precise question at issue." *Id.* at 842. If the intent of Congress is clear, that ends the inquiry, because both the Court and the Secretary "must give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43.

The language of § 1396r-4 nowhere indicates any requirement that out-of-state providers should be considered in implementing the statute. To the contrary, it refers to hospitals "in the state," 42 U.S.C. § 1396r-4(b)(1)(A), (defining a DSH institution); hospitals "in a state," 42 U.S.C. § 1396r-4(f)(1)(A); the "statewide" arithmatic mean, 42 U.S.C. § 1396r-4(f)(1)(A)(I)(b); the utilization rate "for all

hospitals in the state" 42 U.S.C. § 1396r-4(f)(1)(D); and in 42 U.S.C. § 1396r-4(e), the "statewide" pooling arrangement. Especially significant is Congress' determination when enacting the BBA to provide for specific state limits on the amount of DSH each state is entitled to receive. 42 U.S.C. § 1396r-4(f). If Congress' intent was to include out-of-state providers in these calculations, it could have made this point explicitly as it did in § 1396a(a)(16), requiring coverage of services provided to recipients outside of their home state. "[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 U.S. 16, 23 (1983)(citations omitted). The Court should not expand the coverage of the statute, especially in light of the significant policy implications. *See United States v. Stephens*, 208 F.2d 105, 107 (5th Cir.1953) ("[C]ourts cannot, upon the pretence [sic] of construing [a statute], enlarge its coverage to bring within it those not expressly or by clear intendment embraced within its terms.").

Moreover, the Secretary has interpreted § 1396r-4 not to apply to out-of-state providers. It is the Secretary's position that DSH payments need not be made to out-of-State providers because the Medicaid statute does not require that DSH payments be used for "medical assistance" or any other Medicaid-related expenditure, but that the hospital can use the money for any purpose. *See* Brief of United States as *Amicus Curiae*, attorneys for the Secretary of Health and Human Services, in *Children's Hospital and Medical Center v. Belshe*, Docket No. C 95-1076 MHP (N.D. Cal.), at p.17 n.6. [13] Further evidence of the Secretary's position on this

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[13] In a split decision, the Ninth Circuit affirmed the district court's opinion in that matter, finding that the Boren Amendment applied to out-of-state providers notwithstanding the Secretary's interpretation to the contrary. *Children's Hospital and Health Center v. Belshe*, 188 F.3d 1090 (9th Cir. 1999). A petition for a writ of certiorari is currently

issue is found in HCFA's acceptance of New Jersey's State Plan Amendment specifically stating that New Jersey will not make DSH payments to out-of-state hospitals.[14]

Where Congress has not spoken to the precise question at issue, "the question for the court is whether the [Secretary's interpretation] is based on a permissible construction of the statute." *Chevron*, 467 U.S. at 842-43; *Queen of Angels*, 65 F.3d at 1477. A reviewing court need not conclude that the Secretary's interpretation of the statute is the "only reasonable one, or even the 'best' one[,]" *Queen of Angels*, 65 F.3d at 1477, and deference is due the Secretary's reasonable construction of a statute that she administers. *Id.*; *see also Rosado v. Wyman*, 397 U.S. 397, 406-07 (1970). "Confronted with an ambiguous statutory provision, we generally will defer to a permissible interpretation espoused by the agency entrusted with its implementation." *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 414 (1993) (citations omitted).

Similarly, where the Secretary's interpretation of her own regulations is reasonable, a reviewing court must defer to that interpretation. *Shalala v. Guernsey Mem. Hosp.*, 514 U.S. 87, 94-95 (1995); *see also Blum v. Bacon*, 457 U.S. 132, 141 (1982)("interpretation of any agency charged with the administration of a statute is entitled to substantial deference"); *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994); *Udall v. Tallman*, 380 U.S. 1, 16 (1965)("When the construction of an administrative regulation rather than a statute is in issue, deference is even more clearly in order."). Accordingly, the Secretary's administrative interpretation of her regulations must be given "controlling weight unless it is plainly erroneous or inconsistent with the

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pending, 68 U.S.L.W. 3595 (U.S. Mar. 9, 2000)(No. 99-1497).

[14] As HCFA explained in its *Amicus* brief in *Children's Hospital and Medical Center*, its interpretation of the statute is that states can make DSH payments to out-of-state providers, but they are not required to do so.

regulation." *Id.* at 16-17; *accord Thomas Jefferson Univ.*, 512 U.S. at 512.

Thus, as there is no statutory requirement to make DSH payments to out-of-state hospitals, this Court should defer to the Secretary's interpretation. As the Third Circuit noted, "federal approval of the amendment to the plan ... could foreclose a statutory argument challenging the denial of DSH payments." *Children's Seashore House*, 197 F.3d at 661.

C. The Obligation to Make DSH Payments is too Vague to be Judicially Enforced

Lastly, CSH also cannot meet the third prong of the test -- that the obligation is not too vague and amorphous to be judicially enforced. There simply is no longer any requirement in the statute and implementing regulations that the State make elaborate "findings" in order to give "assurances" to HCFA when seeking approval of a rate change. Contrary to the Boren Amendment requirements, there are no specific procedural or substantive requirements which must be met in either 42 U.S.C. § 1396a(a)(13)(A) or 42 U.S.C. § 1396r-4, or any payment standard contained within.

Under *Wilder*, the Supreme Court relied upon the specificity of considerations that the states had to review contained in the Boren Amendment, and measured the states' compliance against a benchmark of "reasonable and adequate" rates:

> [T]he statute and regulation set out factors which a State must consider in adopting its rates. For example, when determining methods for calculating rates that are reasonably related to the costs of an efficient hospital, a State must consider: (1) the unique situation (financial and

> otherwise) of a hospital that serves a disproportionate number of low income patients, (2) the statutory requirements for adequate care in a nursing home, and (3) the special situation of hospitals providing inpatient care when long-term care at a nursing home would be sufficient but is unavailable. 42 U.S.C. § 1396a(a)(13)(A) (1982 ed., Supp. V). In addition, the statute requires the State, in making its findings, to judge the reasonableness of its rates against the objective benchmark of an "efficiently and economically operated facilit[y]" providing care in compliance with federal and state standards while at the same time ensuring "reasonable access" to eligible participants. [*Wilder*, 496 U.S. at 519, and n. 17].

It is abundantly clear that with the repeal of the Boren Amendment, states are no longer required to review a laundry list of considerations and measure whether an efficient facility would be adequately reimbursed.

CSH argues that the criteria in 42 U.S.C. § 1396r-4 requiring a payment adjustment for DSH hospitals evidences Congress' intent that it should receive a DSH payment from New Jersey in addition to what it receives from Pennsylvania. Not only is there no statutory language which requires a state to make DSH payments to out-of-state providers, the statute does not even require any specific level of payment to any hospital, whether in-state or out-of-state. For example, a state can pay "a minimum specified additional payment" as long as the payment is "reasonably related" to "costs, volume, or proportion of services." 42 U.S.C. §

1396r-4(c)(3). This standard is clearly too vague and amorphous to be judicially enforced.

Having failed to establish the three prongs of the test for standing, it is clear that CSH has no standing to bring this action challenging New Jersey's failure to make out-of-state DSH payments as part of its hospital reimbursement scheme. Consequently, the decisions below were correct and there is no basis for granting this petition for a writ of certiorari.

II. There Is No Irreconcilable Conflict Among the Circuit Courts Meriting the Attention of this Court in this Matter.

Petitioner posits that certiorari should be granted because there is a conflict among the circuit courts as to whether hospitals may continue to seek recourse against states following the repeal of the Boren Amendment. However, there is no irreconcilable conflict meriting the attention of this Court.

The alleged conflict arises from the Ninth Circuit's decision in *Children's Hosp. and Health Ctr. v. Belshe, supra*, 188 F.3d 1090, wherein the court held that California must either have payment methodologies that had been validly determined under the Boren Amendment or that complied with the new public process requirements of the BBA. *Id.* at 1095. California did not adopt rates in compliance with the public notice requirements of the BBA. Therefore, the Ninth Circuit evaluated the rates to see if they complied with the Boren Amendment.

In contrast, the Third Circuit in deciding this matter did not apply the Boren Amendment and looked solely to the BBA. *Children's Seashore House*, 197 F.3d at 659.[15]

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[15] The other case cited by petitioner, *Hall v. Sullivan*, 129 F.3d 113, 1997 WL 643921 (2d Cir. 1997), is an unpublished opinion. In that matter the parties agreed that as of whatever date the Boren Amendment

Unlike the Ninth Circuit case, this matter was filed after the Boren Amendment was repealed and the BBA was already in effect. Moreover, on appeal to the circuit court, CSH abandoned its argument that the Boren Amendment applied to this matter and argued solely that the BBA and § 1923 gave rise to standing. Consequently, there is no basis for this Court to grant certiorari on the issue of whether the Boren Amendment still applies.

Furthermore, the Ninth Circuit did not even address the standing issue which is the basis of the Third Circuit's decision. The Ninth Circuit did not examine the three-prong test or make any determination as to whether the plaintiffs had standing to bring the suit under 42 U.S.C. § 1983. Thus, there is no direct legal conflict between the two decisions.

Additionally, even under the holding of the Ninth Circuit case, the ultimate outcome of this matter would not be different because New Jersey complied with the public notice requirements of the BBA. Contrary to California, following the enactment of the BBA, New Jersey complied with the new public process requirements of the BBA when it proposed an administrative regulation on April 6, 1998, which was adopted on June 18, 1998. 30 NJR 1258(a); 30 NJR 2653(a). Consequently, under either circuit court's analysis, the Boren Amendment is inapplicable and only the BBA applies to a determination of the issue.

Lastly, petitioner's argument based upon *Landgraf v. USI Film Products*, 511 U.S. 264 (1994), that the BBA should not be applied retroactively is equally unpersuasive. First, the BBA is not being applied retroactively because New Jersey complied with the BBA's public notice requirements after the BBA was enacted. Moreover, this case was filed after the BBA was enacted and after New Jersey complied with the BBA's requirements,

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was repealed, the appeal would be moot because there cannot be prospective relief to enforce requirements that have been repealed.

making the BBA the law in effect when the operative acts occurred. Further, as this Court noted in *Landgraf*, "[t]he first rule is that 'a court is to apply the law in effect at the time it renders its decision.'" *Id.* at 264 (citation omitted). This is especially appropriate when the intervening statute authorizes or affects the propriety of prospective relief. *Id.* at 275. In the case at bar, the only relief available is prospective injunctive relief.[16] Consequently, the court below was correct in applying the law in effect at the time it rendered its decision, which is the BBA.

Therefore, there is no need for this Court to grant certiorari in this case. The ultimate outcome would be the same whether analyzed based on the Third Circuit's decision or Ninth Circuit's decision. Moreover, the two cases are factually distinct and the reasoning utilized by the Third Circuit below complies with this Court's decision in *Landgraf*.

III. Social and Financial Significance Is Not a Basis for Granting Certiorari

Petitioner asserts that this Court should grant certiorari because DSH payments "implicate significant portions of state and federal budgets" and because there needs to be a method to ensure that states follow the requirements of § 1396r-4. However, these are policy issues that are best left to Congress.

Balancing the social and financial concerns raised by petitioner with the concerns faced by states under the Boren Amendment, Congress enacted the BBA. As noted above, the BBA does not require the payments petitioner seeks. Instead of seeking relief in the appropriate forum, *i.e.* Congress, petitioner is asking this Court to intervene in a

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[16] This is a 42 U.S.C. § 1983 matter against state officials acting in their official capacity only. Therefore, the Eleventh Amendment bars any monetary relief. *Will v. Michigan Dept. of State Police*, 491 U.S. 58 (1989)

policy, rather than legal, issue. Certiorari is simply unwarranted in such a case.

Furthermore, it is respectfully submitted that these policy factors do not change the analysis of whether § 1396r-4 creates a private cause of action. The test is not whether it would be a good thing to allow hospitals to contest their DSH payments. Rather, the test is whether the statute was intended to benefit the plaintiff; whether the provision imposes an unambiguous binding obligation; and whether the interest asserted is too vague and amorphous such that it is beyond the competence of the judiciary to enforce. *Blessing, supra*, 520 U.S. at 340-41. As demonstrated above in Point I, § 1396r-4 fails this test.

In addition, a private right of action is not necessary to ensure that states meet the requirements of § 1396r-4. The federal government still has oversight authority to make sure that states comply with federal law, and HCFA could take measures against any state that violated the provisions of § 1396r-4, including withholding payments. *See* 42 C.F.R. §§ 430.32, 430.33 and 430.35.

In sum, the "social and financial" considerations raised by petitioner do not warrant review of this matter by this Court, especially since the matter was correctly decided by the court below.

IV. There is no Need for this Court to Examine this Matter on an Interlocutory Basis

This matter is currently pending in the district court following the remand by the Third Circuit. Consequently, this appeal is of an interlocutory order.

Ordinarily, this Court will not issue a writ of certiorari to review an interlocutory order of the circuit court of appeals "unless it is necessary to prevent extraordinary inconvenience and embarrassment in the conduct of the cause." *American Construction Co. v. Jacksonville, T. & K. R. Co.*, 148 U.S. 372, 384 (1893). "[E]xcept in extraordinary cases, the writ is not issued until final decree."

Hamilton-Brown Shoe Co. v. Wolf Bros. & Co., 240 U.S. 251, 258 (1916).

The remand of this matter back to the district court by the circuit court is sufficient grounds for denial of this petition. *Ibid. See Brotherhood of Locomotive Firemen v. Bangor & Aroostook R. Co.*, 389 U.S. 327, 328 (1967)(denying certiorari because the Court of Appeals remanded the case, making it unripe for review).

As there is no final order in this matter and no unusual circumstances present in the case at bar, the petition for a Writ of Certiorari should be denied.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

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42 USCA s 1396r-4
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CHAPTER 7--SOCIAL SECURITY
SUBCHAPTER XIX--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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Current through P.L. 106-170, approved 12-17-99

§ 1396r-4. Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

(a) Implementation of requirement

(1) A State plan under this subchapter shall not be considered to meet the requirement of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that--

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) of this section which meets the requirements of subsection (d) of this section), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c) of this section.

(2)(A) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c) of this section, effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f) of this section, effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this subchapter provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(D) A State plan under this title shall not be considered to meet the requirements of section 1369a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to

disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1396n(b)(4) of this title.

(b) Hospitals deemed disproportionate share

(1) For purposes of subsection (a)(1) of this section, a hospital which meets the requirements of subsection (d) of this section is deemed to be a disproportionate share hospital if--

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this subchapter in a period, and

the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of--

(A) the fraction (expressed as a percentage)--

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this subchapter and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)--

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent

patients not eligible for medical assistance under a State plan approved under this subchapter).

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1396b(w)(1)(A)(iii) of this title if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1396b(w)(4) of this title.

(c) Payment adjustment

Subject to subsections (f) and (g) of this section, in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either--

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1) of this section) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2) of this section) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in subsection (b)(3) of this section); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that--

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients,

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a) of this section, the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) of this section (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1395ww(d)(5)(F)(vi) of this title) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) of this section to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) Requirements to qualify as disproportionate share hospital

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital--

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of December 22, 1987.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1395ww of this title), in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2) of this section) of not less than 1 percent.

(e) Special rule

(1) A State plan shall be considered to meet the requirement of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to

the requirement of subsection (a) of this section if (A)(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, (B) the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection, and (C) the plan meets the requirement of subsection (d)(3) of this section and such payment adjustments are made consistent with the last sentence of subsection (c) of this section.

(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a statewide basis, beginning on July 1, 1988--

(A) the requirements of subsections (b) and (c) of this section (other than the last sentence of subsection (c) of this section) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied,

(B) subsection (d)(2)(B) of this section shall apply to hospitals located in urban areas, as well as in rural areas,

(C) subsection (d)(3) of this section shall apply, and

(D) subsection (g) of this section shall apply.

(f) Limitation on Federal financial participation

(1) In general

Payment under section 1396b(a) of this title shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as "DSH") allotment for the State for the fiscal year, as specified in paragraphs (2) and (3).

(2) State DSH allotments for fiscal years 1998 through 2002

The DSH allotment for a State for each fiscal year during the period beginning with fiscal year 1998 and ending with fiscal year 2002 is determined in accordance with the following table:

	DSH Allotment (in millions of dollars)				
State or District	FY 98	FY 99	FY 00	FY 01	FY 02
Alabama	293	269	248	246	246
Alaska	10	10	10	9	9
Arizona	81	81	81	81	81
Arkansas	2	2	2	2	2
California	1,085	1,068	986	931	877
Colorado	93	85	79	74	74
Connecticut	200	194	164	160	160
Delaware	4	4	4	4	4
District of Columbia	23	23	32	32	32
Florida	207	203	197	188	160
Georgia	253	248	241	228	215
Hawaii	0	0	0	0	0
Idaho	1	1	1	1	1
Illinois	203	199	193	182	172
Indiana	201	197	191	181	171

Iowa	8	8	8	8	8
Kansas	51	49	42	36	33
Kentucky	137	134	130	123	116
Louisiana	880	795	713	658	631
Maine	103	99	84	84	84
Maryland	72	70	68	64	61
Massachusetts	288	282	273	259	244
Michigan	249	244	237	224	212
Minnesota	16	16	33	33	33
Mississippi	143	141	136	129	122
Missouri	436	423	379	379	379
Montana	0.2	0.2	0.2	0.2	0.2
Nebraska	5	5	5	5	5
Nevada	37	37	37	37	37
New Hampshire	140	136	130	130	130
New Jersey	600	582	515	515	515
New Mexico	5	5	9	9	9
New York	1,512	1,482	1,436	1,361	1,285
North Carolina	278	272	264	250	236
North Dakota	1	1	1	1	1
Ohio	382	374	363	344	325
Oklahoma	16	16	16	16	16
Oregon	20	20	20	20	20
Pennsylvania	529	518	502	476	449
Rhode Island	62	60	58	55	52
South Carolina	313	303	262	262	262
South Dakota	1	1	1	1	1
Tennessee	0	0	0	0	0
Texas	979	950	806	765	765
Utah	3	3	3	3	3
Vermont	18	18	18	18	18
Virginia	70	68	66	63	59
Washington	174	171	166	157	148
West Virginia	64	63	61	58	54
Wisconsin	7	7	7	7	7
Wyoming	0	0	0.1	0.1	0.1.

(3) State DSH allotments for fiscal year 2003 and thereafter

(A) In general

The DSH allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraph (B), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(B) Limitation

The DSH allotment for a State shall not be increased under subparagraph (A) for a fiscal year to the extent that such an increase would result in the DSH allotment for the year exceeding the greater of--

(i) the DSH allotment for the previous year, or

(ii) 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

(4) Definition of State

In this subsection, the term "State" means the 50 States and the District of Columbia.

(g) Limit on amount of payment to hospital

(1) Amount of adjustment subject to uncompensated costs

(A) In general

A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) of this section with respect to a hospital if the payment adjustment exceeds

the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

(B) Limit to public hospitals during transition period

With respect to payment adjustments during a State fiscal year that begins before January 1, 1995, subparagraph (A) shall apply only to hospitals owned or operated by a State (or by an instrumentality or a unit of government within a State).

(C) Modifications for private hospitals

With respect to hospitals that are not owned or operated by a State (or by an instrumentality or a unit of government within a State), the Secretary may make such modifications to the manner in which the limitation on payment adjustments is applied to such hospitals as the Secretary considers appropriate.

(2) Additional amount during transition period for certain hospitals with high disproportionate share

(A) In general

In the case of a hospital with high disproportionate share (as defined in subparagraph (B)), a payment adjustment during a State fiscal year that begins before January 1, 1995, shall be considered consistent with subsection (c) of this section if the payment adjustment does not exceed 200 percent of the costs

of furnishing hospital services described in paragraph (1)(A) during the year, but only if the Governor of the State certifies to the satisfaction of the Secretary that the hospital's applicable minimum amount is used for health services during the year. In determining the amount that is used for such services during a year, there shall be excluded any amounts received under the Public Health Service Act [42 U.S.C.A. § 201 et seq.], subchapter V of this chapter, subchapter XVIII of this chapter, or from third party payors (not including the State plan under this subchapter) that are used for providing such services during the year.

(B) Hospitals with high disproportionate share defined

In subparagraph (A), a hospital is a "hospital with high disproportionate share" if--

(i) the hospital is owned or operated by a State (or by an instrumentality or a unit of government within a State); and

(ii) the hospital--

(I) meets the requirement described in subsection (b)(1)(A) of this section, or

(II) has the largest number of inpatient days attributable to individuals entitled to benefits under the State plan of any hospital in such State for the previous State fiscal year.

(C) "Applicable minimum amount" defined

In subparagraph (A), the "applicable minimum amount" for a hospital for a fiscal year is equal to the difference between the amount of the hospital's payment adjustment for the fiscal year and the costs to the hospital of furnishing hospital services described in paragraph (1)(A) during the fiscal year.

(h) Limitation on certain State DSH expenditures

(1) In general

Payment under section 1396b(a) of this title shall not be made to a State with respect to any payment adjustments made under this section for quarters in a fiscal year (beginning with fiscal year 1998) to institutions for mental diseases or other mental health facilities, to the extent the aggregate of such adjustments in the fiscal year exceeds the lesser of the following:

(A) 1995 IMD DSH payment adjustments

The total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(B) Applicable percentage of 1995 total DSH payment allotment

The amount of such payment adjustments which are equal to the applicable percentage of the Federal share of payment adjustments made to hospitals in the State under subsection (c) of this section that are attributable to the 1995 DSH allotment for the State for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(2) Applicable percentage

(A) In general

For purposes of paragraph (1), the applicable percentage with respect to--

(i) each of fiscal years 1998, 1999, and 2000, is the percentage determined under subparagraph (B); or

(ii) a succeeding fiscal year is the lesser of the percentage determined under subparagraph (B) or the following percentage:

(I) For fiscal year 2001, 50 percent.

(II) For fiscal year 2002, 40 percent.

(III) For each succeeding fiscal year, 33 percent.

(B) 1995 percentage

The percentage determined under this subparagraph is the ratio (determined as a percentage) of--

(i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) of this section that are attributable to the 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary) for payments to institutions for mental diseases and other mental health facilities, to

(ii) the State 1995 DSH spending amount.

(C) State 1995 DSH spending amount

For purposes of subparagraph (B)(ii), the "State 1995 DSH spending amount", with respect to a State, is the Federal medical assistance percentage (for fiscal year 1995) of the payment adjustments made under subsection (c) of this section under the State plan that are attributable to the fiscal year 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary).

(i) Requirement for direct payment

(1) In general

No payment may be made under section 1396b(a)(1) of this title with respect to a payment adjustment made under this section, for services furnished by a hospital on or after October 1, 1997, with respect to individuals eligible for medical assistance under the State plan who are enrolled with a managed care entity (as defined in section 1396u-2(a)(1)(B) of this title) or under any other managed care arrangement unless a payment, equal to the amount of the payment adjustment--

(A) is made directly to the hospital by the State; and

(B) is not used to determine the amount of a prepaid capitation payment under the State plan to the entity or arrangement with respect to such individuals.

(2) Exception for current arrangements

Paragraph (1) shall not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997.".

December 10, 1997

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Balanced Budget Act of 1997 (BBA). Section 4711 of BBA repeals Sections 1902(a)(13)(A), (B), and (C) of the Social Security Act (the Act), requires states to implement a public process when changes in payment rates or payment methodologies are proposed, and applies to payments for items and services furnished on or after October 1, 1997. (See Enclosure 1 for background on Section 4711.)

Section 4711 of BBA replaced the Boren requirements with a new Section 1902(a)(13)(A) of the Act, which requires states to (a) use a public process for determining rates, (b) publish proposed and final rates, the methodologies underlying the rates, and justifications for the rates, and (c) give interested parties a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications. In the case of hospitals, such rates must take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs.

The intent of Section 4711 is to provide states with maximum possible flexibility, as well as to minimize HCFA's role in reviewing inpatient hospital and long-term care state plan amendments involving payment rate changes. HCFA would consider the state to be in compliance with this provision if it elected to use a general administrative process similar to the Federal Administrative Procedures Act that satisfies the requirements for a public process in developing and inviting comment in Section 4711. This will allow states the flexibility to follow current state public procedures. If a state's public process is not currently being applied to rate setting, or does not currently include a comment period, then the state would need to modify the process. (See Enclosure 2 for public process options.)

The repeal of the Boren amendment cannot be interpreted to be retroactively effective; the Boren amendment still applies to payment for items and services furnished before October 1, 1997. Thus, inpatient hospital and long-term care state plan amendments that are currently pending approval by HCFA, including those where Boren requirement questions are the only outstanding issues, need to have these issues resolved before the amendments can be approved. However, we recognize that the intent in repealing the Boren amendment was to reduce HCFA's role in the institutional payment rate setting process and to increase state latitude in this area. In light of the less restrictive requirements now in place, HCFA is committed to working with states to expedite the resolution of outstanding Boren issues in existing pending amendments.

States that are not proposing changes in their payment methods and standards, or changes in rates for items and services furnished on or after October 1, 1997, need not immediately implement a BBA public process. States need only publish proposed rates, methodologies, and justifications prior to the proposed effective date of any changes in payment rates or payment methodologies. In other words, states are not required to subject their existing rates to a public process to the extent that those existing rates were validly determined in accordance with legal standards in effect prior to October 1, 1997. In the event changes are already underway, states are to submit the preprint page (or comparable language inserted elsewhere in the hospital and long-term care payment sections of the plan) with the next proposed amendment. (See Enclosures 3 and 4 for preprint pages.) We envision a streamlined Federal review process due to the fact that state plan amendments previously submitted under the Boren requirements were subjected to a more rigorous statutory standard both in terms of Federal review of their substance and the review process itself.

Comments or questions regarding this letter may be directed to Marge Lee via e-mail at mlee1@hcfa.gov, or by phone at

410-786-4361. You may also submit them directly to your HCFA regional office contacts. We will all strive to provide you answers in a timely manner.

Sincerely,

Sally K. Richardson

Sally K. Richardson
Director
Center for Medicaid and State Operations

Enclosures

cc:
Jennifer Baxendell
National GovernorsÆ Association

Joy Wilson
National Conference of State Legislatures

Lee Partridge
American Public Welfare Association

All HCFA Regional Administrators

All HCFA Associate Regional Administrators for Medicaid and State Operations

55 FR 10077-01
1990 WL 326009 (F.R.)
(Cite as: 55 FR 10077)

PROPOSED RULES

DEPARTMENT OF HEALTH AND HUMAN SERVICE

Health Care Financing Administration

42 CFR Parts 440 and 447

[BPD-459-P]

Medicaid Program; Payment Adjustments for Hospitals That Serve a Disproportionate Number of Low-Income Patients

Monday, March 19, 1990

AGENCY: Health Care Financing Administration (HCFA), HHA.

ACTION: Proposed rule.

SUMMARY: The chief purpose of these rules is to set forth the requirements and options for Medicaid payments to hospitals that serve a disproportionate number of low-income patients with special needs.

The changes in the Medicaid rules are necessary to reflect specific requirements enacted in 1987 and designated as section 1923 of the Social Security Act in 1988. The intent of section 1923 of the Act is to ensure that, in establishing Medicaid payment rates, States take into account the special needs of these hospitals.

* * * *

***10079**

Questions Raised by States

During the time the disproportionate share provisions have been in effect, several questions have been raised by States, as discussed below.

* * * *

B. Treatment of hospitals that provide Medicaid services to recipients living in States other than the State where the hospital is located.

Some States have asked whether patient days furnished to out-of-State patients would be counted in determining the Medicaid utilization rate.

Section 1923(b)(2) of the Act bases the Medicaid utilization rate on a formula that includes patient days furnished to patients eligible for Medicaid. Section 411(k)(6)(A)(iv) of the MCCA amended section 1923(b)(2) of the Act, by changing "eligible under the State plan" to "eligible under a State plan" (underscoring supplied). This amendment makes clear that the State must consider the total number of patient days attributable to Medicaid recipients regardless of which State would be responsible for payment for the services. This is to ensure that each hospital that meets the Medicaid utilization test or the low-income ratio requirement is accorded disproportionate share status regardless of the origin of those patients.

Supreme Court, U.S.
FILED
MAY 31 2000

(3)

No. 99-1738

IN THE

Supreme Court Of The United States

CHILDREN'S SEASHORE HOUSE,

Petitioner

v.

MICHELLE K. GUHL, Commissioner of the New Jersey Department of Human Services, and MARGARET A. MURRAY, Acting Director of the New Jersey Department of Human Services, Division of Medical Assistance,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF *AMICI CURIAE* NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AMERICAN HOSPITAL ASSOCIATION, VHA INC., PREMIER, NATIONAL ASSOCIATION OF URBAN CRITICAL ACCESS HOSPITALS, CATHOLIC HEALTH ASSOCIATION, AND CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS IN SUPPORT OF PETITIONERS

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INTEREST OF THE PARTIES[1]

Amici curiae are associations and networks of hospitals, health systems and other healthcare providers with a strong shared interest in proper administration and enforcement of statutory requirements of the Medicaid Act, which is found in Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* (hereinafter "Medicaid Act" or "Act"). A full description of each of the individual organizations is included in the attached Appendix. Many members of the *amici* associations and networks are healthcare providers that serve disproportionate numbers of Medicaid recipients and other low-income patients, and are thus recognized by state Medicaid programs under the federal Medicaid statute as providers entitled to receive additional payments. Such providers are often called "disproportionate share hospitals," and the additional payments are often referred to as Medicaid "DSH payments."

The Third Circuit's holding below threatens the ability of DSH hospitals to use the legal process to ensure that states carry out the DSH payment requirements imposed on them by the Medicaid statute. This case is therefore of great importance to such hospitals, insofar as the inability to enforce statutory Medicaid payment requirements could weaken and ultimately destroy the fragile health care safety net that serves the nation's most vulnerable low-income residents.

SUMMARY OF THE ARGUMENT

This case concerns the rights of hospitals under the Medicaid Act. It involves two distinct but related provisions

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[1] This brief was authored solely by counsel for the *amici curiae*. No person or entity other than the *amici* listed herein has made a monetary contribution to the preparation or submission of this brief. Petitioner and respondents have consented to the filing of this brief. Letters expressing consent to that effect have been filed with the Clerk of the Court.

of the Act -- Section 1902(a) (42 U.S.C. § 1396a), which establishes minimum requirements for state Medicaid plans including the requirements in Section 1902(a)(13)(A), and Section 1923 (42 U.S.C. § 1396r-4), which provides particular standards for the recognition and payment of DSH hospitals. These provisions together create what is commonly referred to as the Medicaid DSH payment program.

The issue raised by this case from the perspective of *amici curiae* is quite simple: Whether disproportionate share hospitals have a right of action under 42 U.S.C. § 1983 that may be enforced against states that refuse to comply with the Medicaid DSH payment requirements in Sections 1902(a)(13)(A) and 1923. The Third Circuit found no enforceable statutory right under either section. *Children's Seashore House v. Waldman*, 197 F.3d 654, 659 (3d Cir. 1999).[2] This holding is inconsistent with Supreme Court precedent and conflicts with decisions by other circuits.

If the decision below is allowed to stand, the ability of disproportionate share hospitals to enforce the DSH payment provisions of the Medicaid Act is threatened. A strong, enforceable Medicaid DSH payment program is essential to the delivery of health care services to low-income patients in the absence of universal health insurance coverage. As a result, this case is important not only to *amici* and the provider-members they represent, but also to the estimated 40 million Medicaid recipients and 44 million uninsured individuals who rely on those providers for essential health care.

In addition, the Third Circuit misapplies this Court's precedents in determining whether a right exists under 42 U.S.C. § 1983 to enforce the statutory entitlement to DSH payments. *See Blessing v. Freestone*, 520 U.S. 329 (1997). The court below relies on tangentially relevant legislative action (i.e., the repeal of a completely different statutory requirement

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[2] The text of the Third Circuit's decision is available in Petitioner's Brief at Pet. Br. App. 3a-19a.

known as the "Boren Amendment") and unrelated legislative history in reaching its holding that the DSH payment provisions are unenforceable under 42 U.S.C. § 1983. *Children's Seashore House*, 197 F.3d at 659. A proper analysis using this Court's standards, however, reveals that an enforceable right continues to exist.

The holding below also creates a multi-faceted conflict among the circuits. In particular, the circuits are split regarding whether private rights of action exist under the Medicaid Act, and also regarding the impact of the repeal of the Boren Amendment on the determination of such rights. This conflict will lead to confusion and additional inconsistent rulings on a matter of substantial importance if not addressed by this Court.

ARGUMENT

Rule 10 of the Rules of the Supreme Court of the United States sets forth the considerations governing review on a Petition for Writ of Certiorari. Certiorari is proper in this case because it presents an issue of substantial importance to the nation's low-income patients and the providers that serve them. In addition, the Third Circuit has misapplied Supreme Court precedent in reaching its holding. Finally, in ruling that disproportionate share hospitals cannot sue to enforce relevant provisions of the Medicaid Act, the Third Circuit has created a direct conflict among the circuits.

I. THE COURT SHOULD GRANT THE PETITION BECAUSE THE MEDICAID DSH PAYMENT PROVISIONS ARE CRITICAL TO OUR NATION'S ABILITY TO CARE FOR THE POOR AND UNINSURED, AND HOSPITALS MUST HAVE THE POWER TO ENFORCE THE RIGHTS THAT THE CONGRESS INTENDED TO CREATE FOR THEM

In 1981, the Congress amended the Medicaid Act to require that state payment methodologies take into account the situation of hospitals that serve disproportionate numbers

of low-income patients. Pub. L. No. 97-35, § 2173(B)(ii), 95 Stat. 808 (1981) (amending predecessor to current 42 U.S.C § 1396a(a)(13)(A)). While the states were given some flexibility in implementing the DSH payment provisions, in 1987 the Congress clarified and reinforced this mandate by requiring states to deem certain facilities as disproportionate share hospitals, and requiring states to select from among alternative minimum payment methodologies in setting DSH payment rates for those hospitals. Pub. L. No. 100-203, § 4112, 101 Stat. 1330 (1987) (enacting 42 U.S.C. § 1396r-4).

Pursuant to the Medicaid DSH payment program, states must provide enhanced payments to designated providers in order to assist in covering costs that would otherwise be uncompensated. As detailed in the DSH payment provision itself, such costs include the costs of serving uninsured patients, and the difference between Medicaid payments and the costs of providing services to Medicaid eligibles. 42 U.S.C. § 1396r-4(g). In the context of a rapidly growing uninsured population and intense competition for health care dollars, the Medicaid DSH payment program has become essential to the ability of hospitals to ensure that every American has access to health care services. Contrary to the Third Circuit's assertions, the Congress not only has refused to take action to relieve states of their obligation to DSH hospitals, it has actually imposed additional DSH requirements on states. Yet, the Third Circuit holding threatens to undermine this important program by removing a right of action allowing hospitals to enforce its requirements.

A. The History of the DSH Payment Provisions Reflects a Long-Term and Continuing Congressional Intent to Protect Hospitals Treating a Disproportionate Number of Low-Income Patients

Amici curiae have been extensively involved in the development, modification, and implementation of the Medicaid DSH payment provisions. Prior to 1980 states were required to pay nursing facilities and hospitals serving Medicaid patients their reasonable costs, based on Medicare

principles of provider reimbursement. H.R. Rep. No. 97-158 at 292 (1981). If a state wished to deviate from using Medicare principles, it could do so only by obtaining a waiver. In 1980, the Congress amended the Medicaid Act to provide states with greater flexibility to reimburse nursing facilities based on alternative payment methods without need for a waiver. However, in an amendment first proposed by Oklahoma Senator David Boren, this flexibility was limited in that states were required to find and make satisfactory assurances to the Secretary that their rates were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards ...." Pub. L. No. 96-499, § 962, 94 Stat. 2650-51 (1980) (hereinafter "Boren Amendment"). In 1981, the Congress expanded this additional flexibility in setting Medicaid payment rates to include hospitals. Pub. L. No. 97-35, § 2173(a)(1)(B)(i), 95 Stat. 808 (1981).

In granting states permission to establish new hospital payment methodologies, the Congress simultaneously made clear its concern for the fiscal viability of hospitals that treat "a large volume of Medicaid patients and patients who are not covered by other third party payors." H.R. Rep. No. 97-158 at 294 (1981). To address these concerns, in addition to the Boren Amendment requirement that overall rates be "reasonable and adequate," the Congress also mandated that payment for inpatient services should "take into account the special costs of hospitals whose patient populations are disproportionately composed of [such] individuals." *Id.* at 295. The Act was amended to include the requirement that rates, "in the case of hospitals, take into account the situation of hospitals that serve a disproportionate number of low income patients." Pub. L. No. 97-35, § 2173(a)(1)(B)(ii), 95 Stat. 808 (1981).

Although the history of the DSH provisions is related to the history of the Boren Amendment, it is not identical, and

the purposes of the two provisions differ. In fact, when the Boren Amendment was originally enacted for nursing facilities in 1980, the DSH provisions were not included (and to this day do not apply to nursing facilities). While the Boren Amendment focused on ensuring that overall provider reimbursement rates were "reasonable and adequate," the DSH program's intent was to provide additional funding for hospitals that primarily serve Medicaid and uninsured patients. *See Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511, 519 (5th Cir. 1983) ("[The Boren Amendment] was enacted in 1981 primarily to encourage cost containment in the Medicaid program .... The Congress nevertheless added the [DSH language] to assure that the needs of hospitals with special costs due to a disproportionate number of poor patients were taken into account"). Thus, from its beginnings, the DSH payment requirement was separate from the Boren Amendment's "reasonable and adequate" standard.

Five years later, the Congress became concerned about reports that states were not properly implementing the 1981 DSH payment provision and directed the Secretary of the Department of Health and Human Services (hereinafter "Secretary") to prepare a study reporting on state progress. Pub. L. No. 99-272, § 9519, 100 Stat. 216-217 (1986). The report showed that only 27 states had even defined disproportionate share hospitals and that of these, only 15 states were actually making DSH payment adjustments. H.R. Rep. No. 100-391(I) at 525 (1987).

Indifference to the 1981 DSH provision was not limited to the states. In some instances, the Health Care Financing Administration ("HCFA") of the U.S. Department of Health and Human Services, which administers the Medicaid program, actively deterred states from implementing the DSH payment provision. Recognizing this "startling record of noncompliance," in 1987 the House Budget Committee adopted language in the Omnibus Budget Reconciliation Act of 1987 to enumerate the DSH requirements. Pub. L. No. 100-203, § 4112, 101 Stat. 1330 (enacting 42 U.S.C. § 1396r-4)

(hereinafter OBRA '87). In OBRA '87, the Congress enacted a number of requirements intended to mandate compliance with the original 1981 DSH provision. OBRA '87 provided that:

> A State plan ... shall not be considered to meet the requirement of section 1902(a)(13)(A) ... (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) ... unless [it] ...
>
> > (A) specifically defines [disproportionate share hospitals] ..., and
> >
> > (B) provides ... for an appropriate increase in the rate or amount of payment for [inpatient hospital] services provided by such hospitals ...

Id. at § 4112(a)(1) (42 U.S.C. § 1396r-4(a)(1)). The Congress further deemed certain hospitals to be disproportionate share hospitals and therefore entitled to enhanced payments. *Id.* at § 4112(b) (42 U.S.C. § 1396r-4(b)). Finally, the Congress provided specific instructions on alternative ways for states to calculate the level of DSH payments. *Id.* at § 4112(c) (42 U.S.C. § 1396r-4(c)). The provisions enacted by OBRA '87 are filled with mandatory language, including directives that states and the Secretary "must" or "shall" follow certain procedures in implementing the DSH program.[3] The Congress intended through OBRA '87 to establish once and for all that the DSH provisions were mandatory and to set minimum standards for states and

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[3] *See* 42 U.S.C. §§ 1396r-4(a)(1) ("A state plan under this subchapter *shall not* be considered to meet the requirement of section 1396a(a)(13)(A) ... unless ...), (a)(2)(A) ("[T]he State *must* submit to the Secretary ... (a)(2)(B) ("In order to be considered to have met such requirement ... the State *must* submit ..."), (a)(3) ("The Secretary *shall* ..."), (c) ("[A] payment adjustment for a disproportionate share hospital *must* ...") (emphasis added).

HCFA to follow in implementing the program. H.R. Rep. No. 100-391(I) at 525 (1987). The Third Circuit below erred in finding that this statutory scheme did not confer enforceable obligations on the states that were separate and distinct from those of the repealed Boren Amendment. *See infra* § II(A).

The Congress has taken no action since 1987 that can reasonably be construed as diluting or repealing the specific DSH requirements imposed by OBRA '87. If anything the Congress has increased the number of requirements in the DSH provisions through subsequent legislation.[4] While the Congress clearly repealed the Boren Amendment in the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 514 (1997) (hereinafter "BBA"), it took great care to preserve the DSH requirement in Section 1902(a)(13)(A) and actually enacted additional DSH requirements in Section 1923. *See infra* § II(B).

B. Enforceable Rights to DSH Enhancements are Essential to the Care of Medicaid and Uninsured Patients

There are an estimated 40 million Medicaid recipients in the United States and an additional 44 million individuals without health insurance. The number of uninsured has increased by 11 million over the past decade, and is expected to continue growing at a significant rate. Institute Of Medicine, Summary: America's Health Care Safety Net, Intact But Endangered 4 (2000) (hereinafter "IOM Report"). The uninsured, along with low-income underinsured Americans, Medicaid recipients, and patients with special

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[4] In 1991 the Congress created a national DSH payment target and limited the growth of state DSH programs. Pub. L. No. 102-234, § 3, 105 Stat. 1799-1804 (1991) (42 U.S.C § 1396r-4(f)). In 1993, the Congress placed hospital-specific restrictions on the amount of DSH payments. Pub. L. No. 103-66, § 13621(b) (1993) (42 U.S.C. § 1396r-4(g)).

needs rely on a committed core of "safety net" hospitals for the majority of their health care services. These are the disproportionate share hospitals.

Disproportionate share hospitals are a major source of care for poor Americans. At a time when no consensus exists for adoption of universal health coverage, disproportionate share hospitals step in and provide a kind of national health plan by default. In addition to the substantial volumes of inpatient care typically provided by these safety net institutions, they are major providers of primary and preventive care through both primary care and specialty clinics. Many of these institutions also provide high cost, under-reimbursed specialty care relied upon by the entire community, including trauma care, burn units, neonatal intensive care, and emergency psychiatric services.

Being a safety net hospital, however, is an expensive proposition, and resources to cover the enormous amount of unreimbursed care provided are few and far between. Medicaid, a significant payer for these institutions, often pays less than the true cost of care.

Funding for care to the uninsured and underinsured is extremely fragile. Hospitals once funded uncompensated care largely through "cost shifting"[5] to private sector payers, but are no longer able to do so as competition and managed care have driven down payments to hospitals. Direct governmental support for hospitals treating low-income Americans is therefore extremely important. In addition to Medicaid DSH, sources of such support include a smaller Medicare DSH program, federal categorical grant programs, and state and local government subsidies. None of these are

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[5] Historically, governmental payers frequently paid less than the costs of care to patients sponsored by public programs but private payers typically paid more than the costs of care. Providers used the excess from private patients to subsidize losses on publicly insured and uninsured patients, thus indirectly "shifting the cost" of public patients to private payers.

of the same magnitude as Medicaid DSH, and most have been cut back in recent years. Through this patchwork of support, safety net hospitals have managed to meet the overwhelming demand for their services, but just barely. A threat to any one of these sources of support is a direct threat to continued access to care for low-income patients. The fragility in the institutional financing of care to low-income patients endangers the quality and quantity of services available to those patients in the future. *See generally* IOM Report.

With this backdrop, it is difficult to overemphasize the importance of Medicaid DSH payments for safety net hospitals. Since the Congress' reinforcement of the DSH requirements in OBRA '87, Medicaid DSH has enabled hospitals to care for low-income patients. In 1998, nearly $15 billion was spent by the federal government and the states on Medicaid DSH payments. A study by *amicus* National Association of Public Hospitals & Health Systems (NAPH) revealed that its members (who are almost all disproportionate share hospitals) would have experienced a negative 13 percent margin on Medicaid payments and a negative 7 percent margin on total operations in the absence of DSH payments. Lynne Fagnani & Jennifer Tolbert, The Commonwealth Fund, The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs 19 (1999). Only after DSH payments were included were hospitals able to cover some of their otherwise uncompensated costs. Clearly, DSH payments are essential to providing health care access for millions of low-income Americans.

Hospitals' right to DSH adjustments, however, would be severely undercut if the decision below is allowed to stand and they lose the ability to enforce that right. Several of the detailed requirements set forth in Section 1923 confer rights that HCFA is not actively involved in overseeing and must therefore be enforced by the provider itself if they are to have meaning. For example, the requirement that states deem certain providers as DSH providers, 42 U.S.C. § 1396r-4(b),

or the requirement that payments be made directly to providers and not through managed care arrangements, 42 U.S.C. § 1396r-4(i), are rights that can mean millions of dollars in DSH payments for an individual hospital but are not actively enforced by HCFA. Recourse through the courts is the only option for hospitals wrongfully denied such rights.[6] A right of action to enforce the DSH provisions is therefore key to a meaningful DSH payment program. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 514 (1990) (noting that removing the right to sue for violations of the Boren Amendment "would render [the provision] a dead letter"). Loss of the ability to sue states to enforce DSH provisions would have a significant impact on safety net providers and the patients they serve.

II. THE COURT SHOULD GRANT THE PETITION TO REMEDY THE THIRD CIRCUIT'S MISAPPLICATION OF THIS COURT'S PRECEDENTS

A. The Third Circuit Failed to Apply *Blessing v. Freestone* Appropriately to Determine Whether a Private Right of Action Existed Under 42 U.S.C. § 1983 in Regard to the New Section 1902(a)(13)(A) or Section 1923 of the Medicaid Act

Section 1983 imposes liability on anyone who, under color of state law, deprives a person "of any rights, privileges, or immunities secured by the Constitution and laws" of the United States. 42 U.S.C. § 1983. In order to seek redress under this provision, a plaintiff must assert the violation of a

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[6] *See, e.g., District of Columbia Hosp. Ass'n v. District of Columbia*, 73 F. Supp. 2d 8, 20 (D.D.C. 1999) (finding that defendants ignored "their legal duties as set forth in the governing Medicaid statute" related to DSH payments); *Osteopathic Hosp. Founders Ass'n v. Splinter*, 955 F. Supp. 1351 (N.D. Okl. 1996) (considering a claim regarding plaintiff's rights to DSH payments); *Rye Psych. Hosp. Ctr. v. Surles*, 777 F. Supp. 1142, 1150-1153 (S.D.N.Y. 1991) (considering plaintiff's claim that the state's refusal to declare it a disproportionate share hospital violates Section 1923 of the Act).

federal right, not merely a violation of federal law. *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989). This Court has been very clear in articulating the standards for evaluating a private right's enforceabity under 42 U.S.C. § 1983. Under its reasoning in *Blessing v. Freestone,* an enforceable right exists if three tests are met:

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforceability would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision must be couched in mandatory rather than precatory terms.

520 U.S. 329, 340-41 (1997) (internal citations omitted). *See also Wilder*, 496 U.S. 498. While the Third Circuit gives lip-service to the three-part *Blessing* test in reaching its holding, it does not complete the "methodical inquiry" demanded by this Court.[7] *Blessing*, 520 U.S. at 343.

Contrary to the Third Circuit's analysis, a proper inquiry using the *Blessing* standards demonstrates that enforceable rights exist under either the combination of Section

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[7] After quoting the three-part *Blessing* test, the Third Circuit below merely states:

> [B]y replacing the Boren Amendment with a requirement that a state establish a public process by which its rates would be determined, Congress has removed a party's ability to enforce any substantive right ... Thus, unless [Section 1923] establishes an enforceable right on its own, CSH does not have an enforceable statutory claim ... We are satisfied that CSH cannot predicate its claim on these provisions.

Children's Seashore House, 197 F.3d at 659-660. Without looking at the statute, the Third Circuit relies on legislative history and a district court case to determine that no right exists under Section 1902(a)(13)(A).

1902(a)(13)(A) and Section 1923 or on the basis of Section 1923 standing alone.[8] Under the first prong of *Blessing*, there is little doubt that the Congress intended the DSH provisions to benefit disproportionate share hospitals, since the provisions establish a system for enhanced Medicaid reimbursement of these providers. *Children's Seashore House v. Waldman* (D.N.J. Dec. 7, 1998), Pet. Br. 20a, 27a (district court below found that petitioner and "hospitals like petitioner" were intended beneficiaries of Section 1923). *See also Wilder*, 496 U.S. at 510 ("[H]ealth care providers are the intended beneficiaries [of Section 1902(a)(13)(A)]").

Having satisfied the first test of *Blessing*, the next question is whether the rights provided in Sections 1902(a)(13)(A) and 1923 are not too "vague and amorphous" to be enforced without straining judicial competence. The first point of reference should be the statutory requirements.

The Third Circuit is plainly incorrect in stating that the current Section 1902(a)(13)(A) does not substantively require compliance with the DSH statute. *See Children's Seashore House*, 197 F.3d at 659 ("by replacing the Boren Amendment with a ... public process ... Congress has removed a party's ability to enforce any substantive right"). The federal Medicaid Act clearly imposes specific requirements on states in developing hospital payments and also clearly requires that "in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs." 42 U.S.C. § 1396a(a)(13)(A)(iv). In 1997, the Congress added the parenthetical requirement that such rates must be "consistent with section 1923."

Although Section 1902(a)(13)(A) primarily addresses public notice requirements, the reference to Section 1923 is a

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[8] *Amici* adopt and incorporate the more detailed arguments contained in the Petitioner's brief regarding the application of *Blessing* to *Children's Seashore House*. *See* Pet. Br. at 17-19.

reference to more detailed processes for implementing the substantive right. Conversely, Section 1923 itself acknowledges that it is detailing requirements for implementing the substantive right conferred by Section 1902(a)(13)(A)(iv). *See* 42 U.S.C. § 1396r-4(a)(1) (acknowledging that Section 1902 "requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs"). The language of Section 1923 makes clear that the Congress considers the DSH payment requirement in Section 1902(a)(13)(A)(iv) to be substantive. The requirement is not "vague and amorphous," and it gives rise to an enforceable right.

Moreover, Section 1923 is adequately specific to confer enforceable rights on its own. The section sets forth a number of substantive provisions, including the requirement that a plan amendment "specifically define" disproportionate share hospitals and "include" those hospitals meeting the minimum requirements in the statute. 42 U.S.C. § 1396r-4(a)(1)(A). The statutory requirements also provide two detailed formulae for determining minimum eligibility, 42 U.S.C. § 1396r-4(b), a requirement that states "provide[] for an appropriate increase in the rate or amount of payment for [inpatient] services provided by [disproportionate share] hospitals," 42 U.S.C. § 1396r-4(a)(1)(B), and three alternative methodologies for making payment adjustments, 42 U.S.C. § 1396r-4(c). Whether in conjunction with Section 1902(a)(13)(A) or not, these requirements are concrete and enforceable by the courts.[9]

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[9] *Amici* believe that Section 1902(a)(13)(A) also contains procedural protections that are substantive rights enforceable under 42 U.S.C. § 1983. Apparently concluding that the "public process" language of Section 1902(a)(13)(A) does not include a substantive right, the Third Circuit concludes that there is no enforceable right in the section. This Court acknowledged in *Wilder* however, that procedural rights can be enforced under § 1983. 496 U.S. at 513 ("Any argument that the requirements . . . are procedural requirements only and do not require the State to adopt

The rights at issue in this case are analogous to those examined in *Wilder* and found by the Court to allow a cause of action under § 1983, even though *Wilder* involved the "reasonable and adequate" requirements of the Boren Amendment. *Wilder* noted that Boren was cast in "mandatory rather than precatory terms," quoting the language that a state plan "must" "provide for payment" according to reasonable and adequate rates. 496 U.S. at 512. In the instant case, a state plan "must" "take into account ... the situation of hospitals which serve a disproportionate number of low income patients with special needs." 42 U.S.C. §§ 1396a(a)(13)(A)(iv), 1396r-4. The *Wilder* court also emphasized that the "provision of federal funds is expressly conditioned on compliance" with the requirements in Section 1902(a) – a fact that has not changed with the repeal of the Boren Amendment. 496 U.S. at 512. Finally, the *Wilder* Court rejected an argument that the only right enforceable under 42 U.S.C. § 1983 is "the right to compel compliance" with "bare procedural requirements" as opposed to a substantive right to reasonable and adequate rates. 496 U.S. at 513. The reason for rejecting this argument in *Wilder* applies equally to the rights at issue in this case: to do otherwise "would render the statutory requirements of ... the entire reimbursement provision, [sic] essentially meaningless ... We decline to adopt an interpretation ... that would render [the provision] a dead letter." 496 U.S. at 514. Applying the rationale of *Wilder* to Sections 1902(a)(13)(A) and 1923 in this case, the second prong of *Blessing* is satisfied.

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rates that are actually reasonable and adequate is nothing more than an argument that the State's findings and assurances need not be correct"). Even the dissent in *Wilder*, while arguing against a substantive right to "reasonable and adequate" rates, recognized that a right to enfoce the process established by the statute existed. 496 U.S. at 527-28 ("establishment of rates in accordance with that process is the only discernable right accruing to anyone under § 1396a(a)(13)(A)").

Finally, as required by *Blessing's* third prong, the requirements in Sections 1902(a)(13)(A) and 1902 are binding. It is well settled that although a state's participation in the Medicaid program is voluntary, if a state chooses to participate, its Medicaid plan must comply with the state plan requirements in Section 1902(a) of the Act.[10] *Harris v. McRae*, 448 U.S. 297 (1980). Section 1923 is drafted in mandatory terms and provides specific, enforceable directives for states to follow in implementing Medicaid DSH. Neither of these sections expresses "merely a Congressional preference for a certain kind of conduct," but rather they impose a "binding obligation" on states to treat this special class of hospitals differently. *Wilder*, 496 U.S. at 509.

The Third Circuit violated this Court's dictates in refusing to find that Sections 1902(a)(13)(A) and 1923 meet the *Blessing* requirements.

B. The Boren Amendment Repeal Does Not Change the *Blessing* Analysis or its Outcome, and the History of the Balanced Budget Act of 1997 Demonstrates that the Congress Intended to Preserve and Strengthen the DSH Program

The Third Circuit largely relies on the repeal of the Boren Amendment to support its holding. However, this legislative action did not alter the independent DSH payment requirement or the outcome of the *Blessing* analysis. In fact, the legislative history surrounding the Boren Amendment

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[10] These requirements include, for example, that the plan be mandatory in all political subdivisions of the state; that the state provide for an opportunity for a fair hearing to any individual denied assistance under the Medicaid program; that the state provide safeguards which restrict the use or disclosure of information concerning applicants or recipients of Medicaid assistance; that the state provide for a minimum list of services to Medicaid recipients. 42 U.S.C. §§ 1396a(a)(1), (3), (7), (10). The DSH provision found in Section 1902(a)(13)(A)(iv) incorporating Section 1923, or Section 1923 alone, is no less enforceable under § 1983 than any of these other requirements. See *infra* § III.

repeal supports the assertion that the Congress intended for the DSH provisions to remain enforceable.

In adopting the BBA of 1997, the Congress was clearly troubled by the "reasonable and adequate" provisions in the Boren Amendment. Unlike the precise DSH requirements created by OBRA '87, the Congress never defined the Boren Amendment's "reasonable and adequate" standard. As a result, states and hospitals quickly turned to litigation to give the provision clearer meaning. The crucial case on point was *Wilder*, where this Court held that the "reasonable and adequate" language created an enforceable right. 496 U.S. at 524.

The Congressional reports accompanying the BBA reflect widespread concern with the amount of litigation spawned by the "reasonable and adequate" standard of Section 1902(a)(13)(A) and a desire to grant states more flexibility in rate-setting. *See, e.g.*, H.R. Conf. Rep. No. 105-217 at 867-68 (1997) ("A number of courts found that state systems failed to meet the test of 'reasonableness'"); H.R. Rep. No. 105-149 at 547 (1997) ("Many states have argued that suits or threats of suits under the Boren Amendment have been an important cause of rapid increases in provider reimbursement rates").

Yet nowhere in the volumes of committee reports, floor statements, and testimony on the BBA does anyone in the Congress express a desire to repeal the DSH requirement or render it unenforceable. Rather, the Congress was very deliberate in retaining language in the new Section 1902(a)(13)(A), as well as in Section 1923, requiring states to continue to "take into account ... the situation of hospitals which serve a disproportionate number of low-income patients." To underscore its intent, Congress added a new parenthetical reference within Section 1902(a)(13)(A) to the more specific requirements of Section 1923. *See supra* § II(A). Congress intended to retain the DSH requirement, not to repeal that requirement along with the Boren Amendment. The Conference Report in its characterization of the House Bill further emphasizes this intent. H.R. Conf. Rep. No. 105-217 at 867-68 (1997).

Moreover, despite the repeal of the "reasonable and adequate" requirement by the BBA, the Congress was contemporaneously strengthening the Medicaid DSH program. Specifically, the Congress enacted new language at Section 1923(a)(2) that requires "the State [to] submit to the Secretary ... a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals ... [and] provide an annual report to the Secretary describing the disproportionate share payments to each disproportionate share hospital." Pub. L. No. 105-33, § 4721(c), 111 Stat. 514 (1997) (42 U.S.C. § 1396r-4(a)(2)(D)). The Congress stated that a state plan "shall not be considered to meet the requirements of section 1902(a)(13)(A)(iv)" if these reports are not made. *Id.*; *see also* H.R. Conf. Rep. No. 105-217 at 875 (1997) ("states must submit [information] ... [and] shall make an annual report to the Secretary"). The Congress also added a new requirement that DSH payments made on behalf of Medicaid patients enrolled in managed care plans be paid directly to hospitals rather than the managed care organizations. Pub. L. No. 105-33, § 4721(d), 111 Stat. 514 (1997) (enacting Section 1923(i), 42 U.S.C. §1396r-4(i)).

HCFA clearly believes a substantive DSH mandate still applies. On December 10, 1997, HCFA sent a letter to state Medicaid Directors implementing the new Section 1902(a)(13)(A) and noting the DSH requirement as one of "a number of existing statutory and regulatory requirements . . . [that] remain." On October 8, 1998, HCFA issued a notice in the Federal Register regarding the reporting requirements in Section 1923(a)(2)(D). 63 Fed. Reg. 54142 (Oct. 8, 1998) ("If a title XIX State plan does not specify this methodology by October 1, 1998, it is not in compliance with section 1902(a)(13)(A) of the Act."). On October 6, 1999, HCFA promulgated a proposed rule implementing the new Section 1902(a)(13)(A) which continues to recognize the need to "take into account (in a manner consistent with section 1923 of the Act) the situation of hospitals which serve a disproportionate number of low-income patients." 64 Fed. Reg. 54263, 54267 (to be codified at 42 C.F.R. § 447.254(a)) (proposed Oct. 6, 1999). HCFA clearly

does not believe that the DSH payment requirements have been compromised, and HCFA's interpretation in this instance should be accorded deference. *See Chevron U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984).

The Third Circuit incorrectly relied on the repeal of the Boren Amendment and a case addressing the "reasonable and adequate" provisions of the former Section 1902(a)(13)(A) to find no enforceable right under the current Section 1902(a)(13)(A). The DSH requirement is distinct from the "reasonable and adequate" provisions of the Boren Amendment and must be considered on its own under the *Blessing* analysis. By finding no enforceable right, the Third Circuit ignores the clear intent of the Congress and diminishes the substantive requirements contained in the DSH provisions.

III. THE THIRD CIRCUIT HOLDING ESTABLISHES A CONFLICT AMONG THE CIRCUITS THAT WILL CREATE CONFUSION AMONG OTHER COURTS

Amici adopt and support Petitioner's description and analysis of the conflicts created by the Third Circuit's holding with prior holdings by the Ninth Circuit, and ask the Court to resolve the conflict regarding the enforceability of the DSH payment provisions. In addition, the decision below adds to substantial existing confusion among the circuits with respect to determining whether a right of action exists under provisions of the Medicaid Act. Review of the instant case by the Court provides an opportunity to alleviate substantial confusion.

Although the circuit courts generally recognize *Blessing* as providing the test for determining whether a right exists, there is little to no consistency in the courts' application of the test. A number of the circuit courts, with varying results, have evaluated whether an enforceable right of action exists in regard to Medicaid state plan requirements.[11] The proper application of *Blessing* to

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[11] *Compare Children's Hosp. and Health Ctr. v. Belshe*, 188 F.3d 1090 (9th Cir. 1999) (recognizing an enforceable right to DSH payments), *petition for cert. filed*, 68 U.S.L.W. 3595 (U.S. Mar. 9, 2000) (No. 99-

Medicaid Act requirements remains unclear. The Court should grant review both to address the specific conflict regarding the enforceability of the DSH payment provisions and to alleviate confusion regarding the application of the *Blessing* test to Medicaid plan requirements.

CONCLUSION

For the above stated reasons, we urge the Court to grant the petition for a writ of certiorari.

Respectfully submitted,

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1497); *Concourse Rehabilitation & Nursing Ctr. v. Wing*, 150 F.3d 185 (2d Cir. 1998) (assuming without deciding that state plan requirements create enforceable federal rights); *Boatman v. Hammons*, 164 F.3d 286 (6th Cir. 1998) (finding an enforceable right to a state plan that is "in effect in all political subdivisions of the state"); *Doe v. Chiles*, 136 F.3d 709, 715-718 (11th Cir. 1998) (finding an enforceable right to "reasonable promptness"); *and Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997) (recognizing an enforceable in the Act's "efficiency, economy, and quality of care" provision), *cert. denied*, 522 U.S. 1022 (1998) *with Rite Aid of Pennsylvania v. Houstoun*, 171 F.3d 842 (3d Cir. 1999) (rejecting a right of action in the "efficiency, economy, and quality of care" provision); *and Harris v. James*, 127 F.3d 993, 1010-1012 (11th Cir. 1997) (rejecting a right of action in multiple provisions of the Act).

APPENDIX A

Amici curiae include the following organizations with strong interest in preserving the Medicaid DSH payment program and the right to sue for enforcement of the program's requirements.

National Association of Children's Hospitals (N.A.C.H.)

Representing more than 110 hospitals across the country, including Children's Seashore House and the Children's Hospital of Philadelphia, the National Association of Children's Hospitals (N.A.C.H.) was founded in 1995 as a nonprofit trade association. N.A.C.H. assists its members in addressing public policy issues affecting their ability to fulfill their four-fold missions of providing clinical care, education, research and public health advocacy devoted to all children. An independent corporation, N.A.C.H. is the public policy affiliate of the 32 year-old National Association of Children's Hospitals and Related Institutions (NACHRI), a charitable institution. N.A.C.H. members are among the nation's premier pediatric safety net institutions, pediatric physician and allied health professional training programs, pediatric biomedical and health services research centers, and advocates for children's public health and well-being.

More than 20 percent of all children and 30 percent of all infants rely on Medicaid to pay for their health care; another 11 percent of children are uninsured. Due to their mission to meet the clinical care needs of all children, regardless of economic or medical need, children's hospitals on average devote close to half of their patient care to children who are assisted by Medicaid or are uninsured. Almost every freestanding children's hospital is recognized by its state to be a "disproportionate share hospital" (DSH), and in many states, children's hospitals are among the leading safety net hospitals in receipt of DSH payments. These payments are often substantial, averaging more than $5 million per hospital, and are essential to the sustainable financial health of the hospital.

Without DSH payments, children's hospitals on average receive less than 75 percent reimbursement for their Medicaid expenditures. All of the children's hospitals' missions are affected by the adequacy and reliability of their DSH payments.

National Association of Public Hospitals & Health Systems (NAPH)

The National Association of Public Hospitals & Health Systems (NAPH) was founded in 1981 and represents over 100 metropolitan area hospitals and health systems across the country. These hospitals and systems typically serve as safety net institutions in their communities and are heavily reliant on governmental sources of financing to support care. In 1997, just 69 NAPH members provided nearly one quarter of the uncompensated care in the United States. Over 80 percent of services provided by NAPH members are provided to Medicare, Medicaid, and uninsured patients. Over 65 percent of inpatient care is provided to Medicaid and uninsured patients. The average NAPH member has uncompensated care costs in excess of $61 million, representing over 26 percent of total costs in each institution.

Medicaid DSH payments are of critical importance to NAPH members in subsidizing care provided to the Medicaid population and to the uninsured. Virtually every NAPH member is recognized as a disproportionate share hospital. Medicaid DSH payments provide 22 percent of the funds used to finance the uncompensated care that NAPH members provide. In comparison, only 4 percent of uncompensated care is financed through cost shifting. Without DSH payments, NAPH members would face considerable losses and many would likely be unable to survive.

Association of American Medical Colleges (AAMC)

The Association of American Medical Colleges (AAMC) is a non-profit association whose membership includes 125 U.S. medical schools, 16 Canadian medical schools, and more

than 400 teaching hospitals and health systems. The AAMC's primary mission is to improve the health of the public by enhancing the effectiveness of academic medicine.

In 1998 the AAMC collected financial and operating data from 180 hospital and health system members. Of those members, 54 received Medicaid DSH payments. The mean DSH payment was $32.2 million, and the median payment was nearly $9.7 million. On average, this represents almost 8 percent of net patient service revenue.

American Hospital Association (AHA)

The American Hospital Association (AHA), a not-for-profit association founded in 1898, is the primary national membership organization for hospitals and health systems in the United States. Its membership includes nearly 5,000 hospitals, health systems, networks, and other health care providers. The AHA's mission is to advance the health of individuals and communities; the AHA leads, represents, and serves health care provider organizations that are accountable to the community and committed to health improvement.

Well over 95 percent of the AHA's members participate in the Medicaid program, providing more than $36 billion worth of hospital services to Medicaid patients annually. Because of the important role Medicaid disproportionate share hospitals (DSH) play in their communities, and their dependence on Medicaid DSH payments to serve as safety net hospitals for the most vulnerable Medicaid, uninsured, and underinsured patients, the AHA has a keen interest in seeing that disproportionate share hospitals receive the funding intended for them by Congress. The AHA's advocacy on behalf of Medicaid hospitals and the patients they serve includes participation as *amicus curiae* before this court, e.g. *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498 (1990).

VHA Inc. (VHA)

VHA Inc. (VHA) is a nationwide network of community-owned health care systems and their physicians.

VHA has more than 1,900 members representing over one quarter of the nation's community-owned hospitals and representing some of the nation's leading health care institutions. VHA was founded in 1977 to help preserve the not-for-profit health care philosophy of providing health care. VHA organizations are in 48 of the nation's states (excluding Nevada and Utah).

VHA provides products, programs, and services to help members provide the best possible health care to their patients and communities. VHA offers its members contracts on regional and national products and services in areas such as clinical effectiveness, information technology, learning networks and education, market-share development, performance improvement, and supply-chain management.

Premier

Premier is a strategic alliance of leading hospitals and healthcare systems across the country, representing 212 owners and the 956 hospitals and healthcare facilities they operate, as well as approximately 900 other affiliated hospitals. In addition to offering hospitals substantial pricing discounts through group purchasing agreements, Premier provides a broad-based package of services to its hospital affiliates. Premier has a sizeable stake in the outcome of legislative and regulatory initiatives and is active in the political process regarding issues that enhance healthcare providers' ability to delivery quality care. Premier maintains major offices in Charlotte, NC; San Diego, CA; Chicago, IL; and Washington, DC.

National Association of Urban Critical Access Hospitals (NAUCAH)

The National Association of Urban Critical Access Hospitals (NAUCAH) represents hospitals providing a wide spectrum of services to patients in urban areas. Urban critical access hospitals are located in cities, and are both private and non-profit. They are big and busy, with a bed size of over

250, or total hospital days at or above the 60th percentile of hospitals in comparably sized Metropolitan Statistical Areas. Of more than 6,000 acute-care hospitals in the U.S. fewer than 300 meet all of these criteria.

At least 60 percent of their patient days are reimbursed by Medicare and Medicaid, and at least 10 percent of their patient days are Medicaid days. They also provide a significant amount of charity care. The manner in which urban critical access hospitals are reimbursed gives them a special relationship with the federal government because they are in effect almost totally dependent on government for their reimbursement - and for their survival. Medicare and Medicaid make up the majority of their reimbursement, in many cases it is virtually all of their reimbursement.

Medicaid and Medicare DSH payments are essential for the survival of these hospitals. These payments allow them to maintain their mission and serve low-income and elderly residents in their communities.

Catholic Health Association (CHA)

The Catholic Health Association of the United States (CHA) is the national leadership organization representing the Catholic health ministry. CHA's more than 2,000 members form the nation's largest group of not-for-profit Catholic healthcare systems, sponsors, facilities, health plans, and related organizations. Since its founding in 1915, CHA has worked to strengthen the Catholic health ministry so that it can provide care to everyone, particularly the poor and those least able to care for themselves. CHA is headquartered in St. Louis and has an office in Washington, DC.

Catholic healthcare has a long history of service to low-income communities in the United States, pre-dating the Medicaid program by more than 150 years. On a daily basis, Catholic hospitals provide care to thousands of Medicaid beneficiaries and uninsured individuals consistent with our mission. Adequate Medicaid DSH payments are essential to these hospitals' ability to maintain a strong presence in their communities.

California Association of Public Hospitals and Health Systems (CAPH)

The California Association of Public Hospitals and Health Systems (CAPH), established in 1983, is a trade association representing more than two dozen hospitals, health care systems, and academic medical centers throughout California. Also called "open door providers" because no one is denied access to the essential health care services they provide, CAPH members share a mission and a mandate to provide care to all residents, regardless of their ability to pay. These providers are dedicated to assure the accessibility of cost-effective, high quality, and culturally appropriate health care services for low-income and uninsured populations, beyond those emergency and stabilization services required by law.

CAPH advances public health policies that promote community health, enhance access to health care services for all Californians, support the role of open door providers, and preserve the public health care safety net. CAPH also serves as a resource for information and assistance to members on a variety of state and federal health care policy issues, and has expertise on the Medicaid DSH payment program and other issues of importance to open door providers.